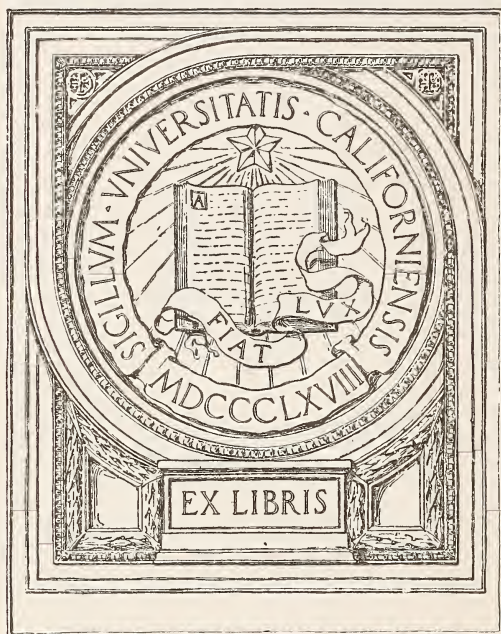


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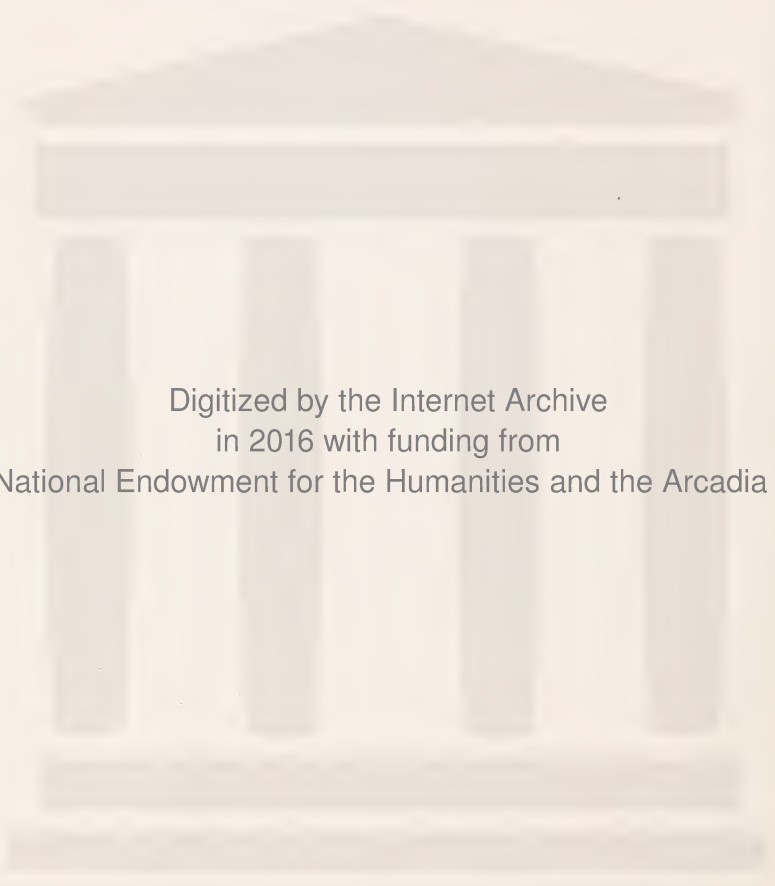


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THE PRESENT STATUS OF DIABETIC TREATMENT.*

By **Frederick M. Allen, M. D.,**

Director of the Physiatrie Institute,
Morristown, N. J.

This paper deals with the present status of the treatment of diabetes, because this is a rapidly developing subject. As the methods and results of today are different from those of a few years ago, so also those of next year or a few years hence are likely to be still different. The treatment in question is a diet treatment, and it finds support in our present idea of the pathology of diabetes.

There is now evidence that diabetes has a double pathology. First, there is the etiologic pathology, the lesion giving rise to the diabetes, which we believe to be caused originally by some infectious or toxic damage of the pancreas. The belief in a nervous etiology, which was formerly widely held, has been largely discredited by recent investigations and by the absence of any increase of diabetes in connection with the psychic stress and strain of the World War. Heredity is a factor in many cases, apparently only in the sense of a predisposition to pancreatic damage, for the same organic changes are found in the pancreas in hereditary cases and in those which appear to be non-hereditary. Excesses in food and the attendant obesity play their part as exciting causes, Joslin¹, in particular, having brought weighty statistical evidence demonstrating the influence of obesity; but if the pancreas is normal no degree of over-eating or over-weight can pro-

duce diabetes. The pancreatic damage referred to may apparently result from any general or local infection which admits micro-organisms or their toxins to the blood stream. The resulting pancreatitis, whether acute or chronic, can seldom be diagnosed clinically. The diabetes in a few instances may come on acutely in evident relation to the preceding infection, or it may lie latent for periods of months or years, as evidenced by the large number of such latent cases which can be discovered by accurate tests. This organic or functional damage created by the initial causative agency is irreparable and hopeless, except in so far as spontaneous regeneration or repair may be possible with the aid of functional rest. The remains of this primary process are generally found at autopsy in the form of fibrous scars, hyalin degeneration, etc., with various degrees of destruction of islands of Langerhans, either selectively or in common, with the acinar tissue.

The second phase of the pathology, in contradistinction to the lesion causing the diabetes, is that which is now known to be the result of the diabetes, namely, the hydropic degeneration of islands of Langerhans. This consists in the appearance of clear spaces in the island cells, which enlarge until the visible cytoplasm is all lost, so that the final appearance is that of a clear vesicle containing a nucleus. Later the cell membrane breaks down and the nucleus degenerates, and the progress of this change steadily reduces the islands in both size and number. These appearances of degeneration were discovered by Weichselbaum in human cases, and are clearly proved by animal experimentation to be the result of over-taxed function of the islands, the cells breaking down in the attempt to meet an en-

*Read at the 156th annual meeting of the Medical Society of New Jersey at Spring Lake, June 23, 1922.

doctrine demand in excess of their capacity². These studies give a clear explanation of a fact long known clinically, namely, that diets in excess of a patient's tolerance result in an irreparable loss of tolerance, while proper limitation of diet largely or wholly checks this downward progress. Patients differ widely in their susceptibility to downward progress and to hydropic degeneration, for unknown reasons. We do not know why young patients are generally so highly susceptible to breakdown of islands and corresponding decline of assimilation, or why cases in adult life differ so widely in their severity and progressiveness. In general, however, the difference is merely one of rate. The elderly patient, who appears able to defy diet rules for many years, ultimately shows the injurious consequences, and the youthful case, with the greatest inherent progressiveness, still responds to the restraining influence of strict diet.

As neither the primary nor the secondary lesions mentioned can be altered by any known medicinal treatment, it follows that many former attempts at therapy are now considered irrational. For example, drugs have no place in the scientific treatment of diabetes, in the sense of any expectation of specific benefit to the diabetic process. Mineral waters of all kinds are valueless, and the only benefit gained by the patients who flock to mineral springs and resorts consists in such dietary treatment as they may receive at these places. Every form of physiotherapy has been tried without demonstration of benefit. Muscular exercise to the degree of maintaining the general health, when the weakness is not too great, is the only one of them that can claim any merit. No preparation has yet become available clinically to supply the needed pancreatic secretion; above all, it has been impossible to obtain results from any

such preparation given by mouth. The proprietary remedies which claim to supply this secretion and which are still used by the medical profession on a wide scale are, therefore, doubly fraudulent. The only method which is known to influence the symptoms and course of diabetes is the treatment by functional rest. This principle is familiar in the management of heart disease, kidney disease and other chronic ailments, and upon this principle the diet of diabetic patients is limited, with a view to relieving the functional burden of the islands of Langerhans, and thereby controlling both symptoms and progressiveness.

For illustrating the results of the present form of diet treatment, I shall refer to our recently published statistics from the Physiatrie Institute³. One difficulty is found in the classification of diabetic cases for this purpose. A certain group of patients, who are seen only for a single consultation or diagnosis, must naturally be excluded. A second group are those who arrive with existing dangerous complications. We have ignored the milder complications, but have grouped the severest ones in a separate table, showing the results of the treatment of complications, as distinct from the treatment of the diabetes itself. (See table below).

The eighteen cases of gangrene were mostly in an advanced stage when seen. The deaths comprise two, in which amputation was stubbornly refused, even when it obviously offered the only chance of saving life, and others in which sepsis and fever were present, when the patients were first seen. When a diabetes (often originally mild) is fanned to intensity of glycosuria and acidosis by septic infection, while at the same time resistance to the spread of the infection is reduced by the diabetes, the combination is well known as excessively critical, and the great majority of such pa-

Table I. Complications existing when patients were first seen.

| | 1919 | | 1920 | | 1921 | | TOTAL | |
|---------------------|---------|-------|---------|-------|---------|-------|---------|-------|
| | Living. | Dead. | Living. | Dead. | Living. | Dead. | Living. | Dead. |
| Gangrene | 3 | 1 | 6 | 4 | 3 | 1 | 12 | 6 |
| Pulmonary Tbc. | 1 | 1 | 0 | 4 | 7 | 4 | 8 | 9 |
| Coma | 1 | 1 | 2 | 3 | 0 | 2 | 3 | 6 |
| Neoplasm | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| Carbuncle | 0 | 0 | 2 | 0 | 3 | 2 | 5 | 2 |
| Total | 5 | 4 | 10 | 11 | 13 | 9 | 28 | 24 |

tients die with or without operation. On the other hand, the outlook for simple dry gangrene is much brighter than before. Of fifteen cases of this type in this series, in ten the necrosis was superficial and healed smoothly under diet. In the remaining five cases the gangrene involved bones and tendons of the feet at the time the patients were first seen. When the deep structures are thus involved, spontaneous healing is impossible and operation inevitable. The absence of systemic infection permitted preliminary diet treatment in all these cases; therefore, acidosis was abolished and the plasma sugar brought below 0.2 per cent. before operation, except in two cases, in which operation was hastened because of advancing gangrene and rise of blood sugar, with low-grade intoxication. In no case of the entire dry gangrene series was there palpable pulsation of any vessels about the ankle. In one case amputation below the knee gave a good result. In the others, amputation above the knee was necessary, because the vessels lower down proved to be almost occluded. All operations were performed under anesthesia with nitrous oxide and oxygen, without glycosuria, acidosis, or other accidents of any kind. In one case of very refractory diabetes, coupled with extreme arteriosclerosis, healing was very slow, and the patient left for his distant home before it was complete. There he overstepped his diet, so as to bring back glycosuria, and a granulating sinus was still present at the time of his death nine months after operation. In the other four cases healing was both prompt and complete, and all are alive with no further trouble from gangrene. A few surgeons still fear to have patients undernourished before operation, but the above results show that such treatment gives far better results than operations performed in the presence of active diabetes. There is probably no difference of opinion among diabetic specialists concerning the fact that strict dietetic treatment offers the best chance for healing if the limb can still be saved, and the best surgical success in cases requiring operation.

Diabetes, with tuberculosis, represents another combination in which each condition tends to make the other worse. When either disease is at all severe, the ultimate prognosis may be considered

hopeless. Any extreme limitation of diet undoubtedly affects the tuberculosis adversely, but not so much so as a state of active diabetic symptoms. After trying stricter and laxer regimes, we have adopted the middle course of nourishing as liberally as possible without producing glycosuria or acidosis, but without attempting to prevent hyperglycemia unless in exceptionally favorable cases. This gloomy ultimate prognosis does not mean that treatment is useless in this condition. The cases with cavity formation and fever, especially in youthful patients with severe diabetes, are the worst and generally run a rapid downward course, as the infection has its usual influence in breaking down the food tolerance and the diabetes lowers resistance to the infection. Nevertheless, even in these most hopeless cases, diet treatment sometimes accomplishes a striking gain, both in comfort and length of life, as exemplified in a case previously reported⁴. In a middle class may be placed cases of more or less severe diabetes, complicated with fibroid phthisis. Here the toxic absorption is less and the prognosis correspondingly better. The one living patient among those seen in 1919 was of this type. He was aged thirty years at that time, and may have had both diabetes and tuberculosis for the preceding two years, according to the rather vague history. With symptoms of bronchitis, tubercle bacilli were numerous in the sputum in one examination, but both the bronchitis and the bacilli quickly disappeared under strict diet treatment. It proved feasible to build up a tolerance of 70 gm. protein, 25 gm. carbohydrate and 1600 calories, while keeping the blood sugar normal. Through unwise attempts at work and many departures from diet, tolerance has gradually been lost and finally bacilli have reappeared in the sputum. If we had planned better for supervision of the patient while at home, the favorable result could have been maintained much longer in such a case. The third group to be mentioned are the older patients with diabetes and tuberculosis in milder forms, and some of these permit the best results of all. Therefore, notwithstanding the bad general outlook, and the fact that no ultimate hope is entertained for any of the patients in Table I with this combination, diet treatment offers enough bene-

fit that it should be carried out accurately in practically all such cases, even when stringent measures are necessary to stop the glycosuria.

Diabetic acidosis remains an extremely dangerous complication when it has been allowed to develop to the stage of coma or pre-coma. The earlier stages are generally easy to check and have not been included in Table I. The cases there shown were in an advanced stage when seen, as is sufficiently indicated by the mortality. No patient has developed coma or serious acidosis under treatment, for when the undernutrition regime is properly carried out there is no need for such accidents. For reasons of brevity it is impossible to enter into a detailed analysis of methods or results. It is also not desired to enter into the prevailing discussion over the use or non-use of alkali. Our results in attempting to treat the extreme stages of diabetic acidosis have been bad, as shown by the fact that 6 patients died and only 3 survived. The majority of these patients received sodium bicarbonate in various ways and quantities, mostly by mouth. Joslin uses no alkali, and his results, which he has partly published and doubtless will later publish more fully, are the best ever recorded, as judged by the fact that he has saved a greater number of patients having lower plasma bicarbonate figures than any other writer. The difference in methods between the different persons who use the newer diet methods is really slight, as it pertains to only a few cases. There is seldom any need for soda, and most competent judges will doubtless agree that the more moderate degrees of diabetic acidosis can be cleared up easily and smoothly by diet alone. It is a natural inquiry why we cling to the use of bicarbonate in the small number of desperate cases, if statistics carry any weight and if Joslin's results appear better than our own. Our excuses are three. First, we believe that the high mortality is due to the excessive severity of our cases. This cannot be proved by the plasma bicarbonate figures, which were higher than those of Joslin's cases and also higher than those in a number of the acidosis cases in the Rockefeller Institute series⁵ which recovered. This bicarbonate level was due to the considerable quantities of alkali which most of these patients had received before we

saw them, and which, according to Joslin's view, might increase their danger. Second, the results in the cases treated without alkali were as fatal as those in the cases with alkali, and the three patients who recovered were among those who received alkali. Third, in 2 instances (one of the cases mentioned, and one seen in 1922) progress which seemed highly unfavorable under treatment without alkali was apparently turned to recovery by administration of sodium bicarbonate.

However this question may be decided, there can be no doubt of the great service rendered by Joslin toward correcting the prevalent abuse of alkali. Not only has bicarbonate been used to the exclusion of more rational measures for dangerous acidosis, but many physicians have prescribed it as a routine upon the first appearance of acetonuria or even at the first diagnosis of diabetes. Attention should be centered upon preventing the formation of acids rather than upon attempts to neutralize them. Therefore the milder grades of acetonuria are cleared up by stopping the loss of sugar in the urine and by properly balanced diets. For impending coma, the most important measure is the withdrawal of all food except the carbohydrate of citrus fruit juices, made into drinks for administering maximal quantities of fluid. Vigorous purgation apparently helps. Additional fluid may be given intravenously or subcutaneously when needed in the form of saline solution. Alkali injections are sometimes dangerous and seldom if ever helpful, but we have observed no harm from reasonable doses of sodium bicarbonate by mouth or rectum during the emergency. All are agreed upon the principal features of this plan. If the mortality from coma can be reduced as low everywhere as in Joslin's clinic, the question of alkali will be seen to have small practical importance.

Carbuncle may be discussed in the same sense as gangrene. The issue is determined largely by the severity of the infection and of the diabetes, both of which are difficult to control in the crisis. If surgery can reduce the toxic absorption, the diabetes is benefited, and if coma be avoided and the glycosuria cleared up by careful diet, the resistance to the infection will be increased.

In summary, it may be concluded that still represent dangerous emergencies all complications are treated with great- and involve a high mortality. er success than some years ago, but they

Table II. Mortality of cases classified by years in which first seen.

| 1919 | | | | | | | | | | | | |
|--------|-------------|-----------------------|--------|------|---|----------------|-------------|---------------------|------|------------------------------------|-------------|-------------------|
| Decade | Total Cases | FAITHFUL TO TREATMENT | | | | Cause of death | Mortality % | ABANDONED TREATMENT | | | | Total Mortality % |
| | | Cases | Living | Dead | Cases | | | Living | Dead | Cause of death | Mortality % | |
| 1 | 2 | 1 | 1 | 0 | | 0.0 | 1 | 1 | 0 | | 0.0 | |
| 2 | 6 | 5 | 3 | 2 | 2 inanition | 40.0 | 1 | 0 | 1 | 1 coma | 100.0 | |
| 3 | 4 | 2 | 2 | 0 | | 0.0 | 2 | 1 | 1 | 1 coma | 50.0 | |
| 4 | 6 | 6 | 3 | 3 | 1 influenza 1 nephritis 1 inanition | 50.0 | 0 | 0 | 0 | | 0.0 | |
| 5 | 11 | 5 | 5 | 0 | | 0.0 | 6 | 4 | 2 | 2 coma | 33.3 | |
| 6 | 10 | 6 | 6 | 0 | | 0.0 | 4 | 3 | 1 | 1 cirrhosis of liver | 25.0 | |
| 7 | 6 | 3 | 3 | 0 | | 0.0 | 3 | 3 | 0 | | 0.0 | |
| | 45 | 28 | 23 | 5 | | 17.9 | 17 | 12 | 5 | | 29.4 | |
| | | | | | | | | | | | 22.2 | |
| 1920 | | | | | | | | | | | | |
| 1 | 6 | 2 | 2 | 0 | | 0.0 | 4 | 1 | 3 | 3 coma | 75.0 | |
| 2 | 13 | 7 | 7 | 0 | | 0.0 | 6 | 2 | 4 | 4 coma | 66.6 | |
| 3 | 16 | 8 | 8 | 0 | | 0.0 | 8 | 2 | 6 | 6 coma | 75.0 | |
| 4 | 20 | 9 | 8 | 1 | 1 inanition | 11.1 | 11 | 7 | 4 | 3 coma, 1 neuro-syphilis | 36.3 | |
| 5 | 29 | 14 | 14 | 0 | | 0.0 | 15 | 11 | 4 | 3 coma, 1 nephritis | 26.6 | |
| 6 | 32 | 17 | 16 | 1 | 1 uncontrollable severity | 5.8 | 15 | 11 | 4 | 2 coma, 1 nephritis 1 psychosis | 26.6 | |
| 7 | 14 | 9 | 8 | 1 | 1 apoplexy | 11.1 | 5 | 3 | 2 | 2 coma | 40.0 | |
| 8 | 3 | 3 | 2 | 1 | 1 heart failure | 33.3 | 0 | 0 | 0 | | 0.0 | |
| | 133 | 69 | 65 | 4 | | 5.8 | 64 | 37 | 27 | | 42.2 | |
| | | | | | | | | | | | 23.4 | |
| 1921 | | | | | | | | | | | | |
| 1 | 22 | 14 | 14 | 0 | | 0.0 | 8 | 5 | 3 | 3 coma | 75.0 | |
| 2 | 30 | 22 | 22 | 0 | | 0.0 | 8 | 3 | 5 | 1 pneumonia, 4 coma | 62.5 | |
| 3 | 20 | 15 | 15 | 0 | | 0.0 | 5 | 4 | 1 | 1 coma | 20.0 | |
| 4 | 48 | 32 | 30 | 2 | 1 inanition 1 pneumonia | 6.2 | 16 | 11 | 5 | 5 coma | 31.2 | |
| 5 | 69 | 50 | 49 | 1 | 1 inanition | 2.0 | 19 | 19 | 0 | | 0.0 | |
| 6 | 71 | 50 | 49 | 1 | 1 inanition | 2.0 | 21 | 18 | 3 | coma, 1 inanition 1 gangrene | 14.2 | |
| 7 | 33 | 26 | 26 | 0 | | 0.0 | 7 | 7 | 0 | | 0.0 | |
| 8 | 9 | 6 | 6 | 0 | | 0.0 | 3 | 3 | 0 | | 0.0 | |
| | 302 | 215 | 211 | 4 | | 1.8 | 87 | 70 | 17 | | 19.5 | |
| | 480 | 312 | 299 | 13 | | 4.2 | 168 | 119 | 49 | | 29.7 | |
| | | | | | | | | | | | 6.9 | |
| | | | | | | | | | | | 12.9 | |

*Total for 3 years.

The cases in Table II are divided according to the years in which they were first treated at this Institute, irrespective of the previous duration of the diabetes. In one class have been placed those who still report in person or by mail for advice, and who are reasonably faithful to diet. In another class are placed all who have abandoned the treatment, by discarding all restrictions, or refusing to follow advice, or changing to some other physician, or removal to too great a distance, or in any other way. The mortality figures cover all deaths among these patients up to January 1, 1922, i. e., the deaths recorded for the respective years are not limited to those occurring in those years.

Thus, there were forty-five patients treated in 1919, of whom twenty-eight have remained faithfully under treatment up to January 1, 1922, and seventeen have broken or changed treatment. Among the twenty-eight faithful, the deaths up to January 1, 1922, have been five, or 17.9 per cent. Among the seventeen unfaithful, the deaths have been five, or 29.4 per cent.

In 1920 there were 133 patients received for treatment, of whom sixty-nine have remained faithful to January 1, 1922, and sixty-four have abandoned or changed treatment. Among the sixty-nine faithful, the deaths up to January 1, 1922, have been four, or 5.8 per cent. Among the sixty-four unfaithful, the deaths have been twenty-seven, or 42.2 per cent.

The patients seen for the first time in 1921 numbered 302. Of these, 215 continued faithful to treatment to January 1, 1922, and eighty-seven abandoned or changed treatment. Among the 215 faithful, the deaths up to January, 1922, have been four, or 1.8 per cent. Among the eighty-seven unfaithful, the deaths have been seventeen, or 19.5 per cent.

Increased mortality is naturally to be expected with passage of more time, from both diabetic and non-diabetic causes. Thus, reckoned up to January 1, 1922, the total mortality among the patients treated in 1919 has been 22.2 per cent., that among the patients treated first in 1920 has been 23.4 per cent., and that among the patients received in 1921 has been 6.9 per cent. The total mortality for the three years amounts to sixty-two among 480 patients, or 12.9 per cent.

These figures serve to show the results regarding preservation of life among patients undertaking regular treatment, whether this was continued faithfully or not. For statistical interest the total may be completed by adding the deaths shown in Table I, which occurred from initial complications, so that they did not serve for a test of the regular treatment. Thus, the deaths from initial complications in 1919 were four, and those among treated patients were ten, making a total of fourteen among forty-nine patients, or 28.6 per cent. The deaths from initial complications in 1920 were eleven, and those among treated patients were thirty-one, making a total of forty-two among 144 patients, or 29.2 per cent. The deaths from initial complications in 1921 were nine, and those among treated patients were twenty-one, making a total of thirty among 311 patients, or 9.6 per cent. The entire mortality thus was eighty-six among 505 patients, or 17.0 per cent.

Observations Concerning Mortality.—The difference in death-rate between unfaithful patients and those faithful to treatment is sufficiently marked to encourage strictness and fidelity, especially as there can be no doubt in the minds of those knowing these individuals that the latter class have also had easier and more comfortable lives than the former. Additional notice may be taken, however, of the fact that the mortality among the unfaithful patients is not strikingly high, especially in relation to the severity of the cases, as indicated by their age and food tolerance. When the patients merely turned to other physicians, the treatment of these latter may receive credit, but this was true in only a minority of instances. The great majority of those who broke off treatment gave up attempts at diet, or tried faith cures or quack remedies, or violated the diets of the physicians to whom they subsequently applied. In the great majority of cases, therefore, glycosuria was brought back, and the statistics apply to this condition. They serve, for one thing, to refute an impression which has gained some acceptance, that the weakening effect of an undernutrition treatment hastens the death of such patients as subsequently break diet. This impression may sometimes be created by cases which have gone on for years, until such a severe stage has been

reached that life can be saved only by drastic measures. Such patients may be kept alive for a certain time by such measures, and then, if they tire of the hardships and eat recklessly, may die rather quickly, but the actual fault lies not in the later strictness which kept them alive, but in the earlier laxness which brought them to such a state of severity. It was previously pointed out⁶ that the overwhelming majority of such patients die not from inanition, but from coma. There can be no valid doubt that they are safer from acidosis after the acetone has once been thoroughly cleared up and the body weight reduced, and the above statistics give a further illustration of this fact. In addition, few patients totally forget the discipline of a properly conducted institution, the instruction in food values received there, and the lessons learned from their observations of other patients. Some confirmed violators of diet are thus reformed. Even those with the least intelligence or self-control generally make at least occasional efforts to stop their glycosuria or restrain it within moderate bounds, and the results are evident in the longer duration of life. Their downward progress, however, manifests itself not only by increasing symptoms, but also by the rise of mortality with each year that goes by.

Observations Concerning Causes of Death.—Of the forty-nine deaths among patients unfaithful to treatment, thirty-seven were due to coma. Two deaths were due to other diabetic causes, viz., inanition in one case and gangrene in another. Another patient went insane and died a few weeks later, the trouble being probably independent of her diabetes. There were four deaths due to definitely non-diabetic causes, viz., nephritis, 2 cases; cirrhosis of the liver, 1 case, and cerebrospinal syphilis, 1 case. Among the patients faithful to treatment, inanition was responsible for the greater number of deaths, viz., seven. The plain meaning of this term is that the diabetes was so severe that death resulted after a longer or shorter period from starvation, due to inability to acquire tolerance for any living diet. In one case of this sort coma was finally permitted as the alternative, the condition being entirely hopeless, notwithstanding the patient's fidelity. The death from influenza pneumonia in one case

may have been independent of diabetes, as the infection was then epidemic, but responsibility is nevertheless accepted under the head of diabetes, as this may have heightened the susceptibility to the infection or the attendant weakness may have induced the fatal result. Three of the fatalities were definitely independent of diabetes, viz., nephritis, apoplexy and heart disease, one case each.

By a reckoning on this basis, the death-rate from diabetes in this series could be somewhat reduced, if desired. It is more important, however, to call attention to the lack of diabetic complications among the cases under treatment. Except for the one case of hopeless severity, coma was absent, because acidosis was not permitted. Tuberculosis has not appeared in any patients other than those (Table I) in whom it was present at entrance. The patients faithful to treatment have also enjoyed complete immunity to gangrene, carbuncle and other complications. As active diabetes is far more dangerous than undernutrition in creating susceptibility to all sorts of infections and injuries, the same may be expected to hold true for tuberculosis. The strongest possible emphasis should, therefore, be placed upon strict dietetic control for the prevention of tuberculosis, as well as of all other diabetic complications.

Observations Concerning Fidelity to Treatment.—Some former opinions of unreliability of diabetics are untrue, for the majority of them will follow diet conscientiously, when convinced of the benefit and instructed in regard to accurate and appetizing preparation of food. They have not always been treated fairly in statistics, which have been planned to show as low a death-rate as possible under institutional care, and have not taken proper account of those who were discharged as hopeless to die at home, where they might break diet either from ignorance, despair or intolerable privations. It is essential that any treatment shall be not only theoretically advantageous, but also suitable for practical application. The test of any dietary regime is two-fold: First, the benefit to patients who actually follow it, and second, the proportion of patients who will consent to follow it. Thorough control imposes hardships proportioned to the severity of the diabetes, but on the other hand it inspires

confidence if real control is achieved, and if the benefit is sufficiently evident to convince the patient. The atmosphere of fidelity and hope in a diabetic institution depends upon its results, and in turn is the greatest aid to further results. The menus must be so prepared as to avoid any intolerable suffering from hunger. With rational conduct thus made possible, patients of average intelligence and self-control will be governed more by the actual experience of themselves and the other patients whom they meet than by anything that any physician can tell them. The fact that such a large proportion of

them will continue faithful, even under extreme privations, affords good evidence of benefit. (See Tables 3 and 4.)

Initial undernutrition has been the method used in the treatment of all of these patients, but in a brief talk it is impossible to go into details of diet. In general, we seldom employ continuous fasting at the outset, but accomplish the same purpose more comfortably by very low diets, for example, fifteen or twenty grams of protein daily without other food, except, perhaps, five or ten grams of carbohydrate, as previously described⁷. In the more refractory cases single days of complete fasting may be

Table III.

Cases in 1st and 2nd decades 5 lbs. or more under standard weight on admission.
Total of 79 cases.

| FIRST DECADE | | | SECOND DECADE | | |
|--------------|--|--|---------------|--|--|
| Case No. | Pounds under standard weight on admission. | Change in body weight since admission. Pounds. | Case No. | Pounds under standard weight on admission. | Change in body weight since admission. Pounds. |
| 44 | 8 | — 7 | 1 | 15 | —20 |
| 75 | 7 | — 4 | 23 | 56 | —12 |
| 123 | 8 | +13 | 175 | 18 | —17 |
| 331 | 10 | — 2 | 184 | 10 | — 3 |
| 363 | 8 | — 2 | 187 | 21 | — 1 |
| 381 | 6 | — 1 | 205 | 23 | — 3 |
| 410 | 8 | — 2 | 336 | 19 | —15 |
| 539 | 14 | + 7 | 337 | 37 | — 4 |
| 541 | 16 | +12 | 339 | 12 | + 1 |
| 574 | 11 | — 4 | 340 | 12 | — 3 |
| 603 | 10 | — 2 | 384 | 11 | —18 |
| 616 | 6 | — 1 | 443 | 12 | +12 |
| 747 | 6 | — 3 | 465 | 26 | + 7 |
| 768 | 10 | — 2 | 474 | 19 | — 1 |
| 806 | 12 | — 3 | 514 | 42 | — 1 |
| 834 | 11 | — 4 | 534 | 11 | +30 |
| 843 | 10 | — 2 | 540 | 22 | —11 |
| 881 | 12 | — 3 | 553 | 18 | — 1 |
| 1070 | 30 | — 2 | 578 | 10 | + 6 |
| | | | 587 | 16 | —19 |
| | | | 659 | 6 | — 1 |
| | | | 709 | 11 | — 1 |
| | | | 759 | 19 | — 7 |
| | | | 780 | 5 | — 2 |
| | | | 786 | 22 | — 3 |
| | | | 826 | 30 | — 5 |
| | | | 911 | 50 | —11 |
| | | | 970 | 18 | — 6 |
| | | | 1009 | 30 | — 4 |
| | | | 1016 | 35 | —17 |
| | | | 1020 | 14 | — 4 |
| | | | 1052 | 13 | — 3 |
| | | | 1055 | 13 | — 4 |
| | | | 1069 | 46 | — 2 |
| 19 cases | | | 34 cases | | |

Table IV.

Adults 20 pounds or more under standard weight on admission.

| Case No. | Age. | Pounds below standard weight on admission. | Pounds reduced after admission. | Case No. | Age. | Pounds below standard weight on admission. | Pounds reduced after admission. | Case No. | Age. | Pounds below standard weight on admission. | Pounds reduced after admission. |
|----------|------|--|---------------------------------|----------|------|--|---------------------------------|----------|------|--|---------------------------------|
| 5 | 27 | 21 | 7 | 317 | 27 | 28 | 3 | 718 | 51 | 30 | 8 |
| 6 | 62 | 40 | 20 | 320 | 37 | 25 | 8 | 724 | 70 | 60 | 16 |
| 24 | 27 | 50 | 12 | 328 | 26 | 31 | 30 | 725 | 45 | 68 | 19 |
| 25 | 43 | 51 | 12 | 343 | 59 | 27 | 27 | 731 | 29 | 42 | 15 |
| 31 | 35 | 51 | 6 | 347 | 50 | 32 | 2 | 734 | 55 | 45 | 1 |
| 41 | 33 | 54 | 20 | 355 | 58 | 37 | 11 | 739 | 30 | 21 | 3 |
| 49 | 64 | 20 | 7 | 356 | 33 | 22 | 2 | 743 | 47 | 45 | 17 |
| 56 | 36 | 22 | 5 | 371 | 31 | 37 | 20 | 746 | 51 | 32 | 1 |
| 60 | 30 | 23 | 33 | 382 | 24 | 20 | 8 | 752 | 55 | 61 | 5 |
| 69 | 59 | 27 | 12 | 391 | 47 | 23 | 3 | 753 | 35 | 47 | 11 |
| 70 | 28 | 29 | 11 | 402 | 48 | 24 | 9 | 766 | 37 | 49 | 16 |
| 76 | 27 | 30 | 16 | 409 | 32 | 32 | 0 | 767 | 70 | 39 | 14 |
| 77 | 48 | 21 | 7 | 413 | 25 | 31 | 4 | 771 | 55 | 28 | 1 |
| 84 | 53 | 24 | 7 | 423 | 33 | 30 | 11 | 774 | 36 | 45 | 2 |
| 85 | 31 | 52 | 12 | 432 | 59 | 54 | 10 | 790 | 39 | 52 | 4 |
| 100 | 63 | 24 | 20 | 436 | 47 | 40 | 23 | 793 | 56 | 85 | 9 |
| 125 | 52 | 66 | 22 | 439 | 31 | 75 | 4 | 795 | 27 | 72 | 14 |
| 137 | 45 | 36 | 3 | 447 | 35 | 24 | 11 | 801 | 35 | 56 | 6 |
| 145 | 43 | 46 | 10 | 448 | 36 | 49 | 4 | 813 | 32 | 54 | 5 |
| 149 | 55 | 41 | 5 | 457 | 56 | 21 | 10 | 816 | 46 | 24 | 1 |
| 150 | 35 | 22 | 1 | 466 | 40 | 38 | 10 | 818 | 45 | 30 | 9 |
| 156 | 22 | 37 | 12 | 471 | 33 | 25 | 2 | 820 | 38 | 26 | 7 |
| 160 | 58 | 55 | 9 | 475 | 62 | 29 | 4 | 823 | 25 | 57 | 9 |
| 162 | 50 | 36 | 2 | 476 | 21 | 44 | 2 | 824 | 49 | 23 | 16 |
| 168 | 37 | 54 | 6 | 487 | 35 | 23 | 10 | 828 | 44 | 49 | 1 |
| 173 | 36 | 21 | 39 | 499 | 51 | 83 | 2 | 833 | 36 | 47 | 18 |
| 174 | 42 | 47 | 11 | 509 | 51 | 33 | 8 | 837 | 41 | 20 | 8 |
| 177 | 25 | 29 | 20 | 511 | 61 | 40 | 22 | 839 | 43 | 46 | 15 |
| 180 | 70 | 25 | 10 | 515 | 60 | 21 | 18 | 840 | 63 | 28 | 3 |
| 200 | 53 | 21 | 3 | 526 | 48 | 31 | 8 | 844 | 64 | 35 | 7 |
| 208 | 43 | 21 | 5 | 531 | 51 | 35 | 33 | 846 | 29 | 25 | 1 |
| 211 | 60 | 35 | 8 | 532 | 24 | 23 | 15 | 849 | 60 | 28 | 13 |
| 212 | 63 | 22 | 5 | 535 | 44 | 40 | 12 | 856 | 29 | 40 | 2 |
| 214 | 26 | 41 | 3 | 542 | 46 | 40 | 4 | 863 | 24 | 36 | 9 |
| 219 | 41 | 53 | 2 | 548 | 30 | 62 | 20 | 867 | 25 | 22 | 9 |
| 225 | 55 | 49 | 18 | 573 | 33 | 25 | 20 | 874 | 47 | 35 | 10 |
| 228 | 64 | 32 | 23 | 591 | 44 | 35 | 16 | 885 | 50 | 35 | 1 |
| 232 | 40 | 25 | 8 | 611 | 61 | 31 | 5 | 915 | 30 | 32 | 2 |
| 235 | 45 | 25 | 14 | 612 | 59 | 33 | 6 | 926 | 50 | 41 | 10 |
| 242 | 69 | 27 | 4 | 618 | 34 | 38 | 6 | 927 | 64 | 26 | 4 |
| 246 | 24 | 32 | 5 | 620 | 50 | 20 | 14 | 932 | 40 | 41 | 23 |
| 248 | 42 | 36 | 18 | 629 | 37 | 37 | 32 | 947 | 47 | 28 | 2 |
| 251 | 56 | 29 | 2 | 642 | 32 | 29 | 5 | 949 | 55 | 37 | 3 |
| 265 | 49 | 29 | 25 | 647 | 55 | 43 | 10 | 975 | 32 | 25 | 4 |
| 283 | 29 | 38 | | 653 | 36 | 39 | 8 | 1003 | 40 | 26 | 10 |
| 286 | 55 | 78 | 5 | 654 | 57 | 40 | 13 | 1012 | 55 | 21 | 1 |
| 291 | 49 | 46 | 13 | 668 | 60 | 42 | 4 | 1033 | 56 | 23 | 12 |
| 304 | 45 | 57 | 16 | 676 | 29 | 33 | 16 | 1044 | 47 | 42 | 9 |
| 312 | 56 | 42 | 3 | 683 | 56 | 41 | 1 | 1048 | 41 | 70 | 11 |
| 314 | 43 | 40 | 9 | 687 | 61 | 41 | 14 | 1049 | 49 | 51 | 18 |
| 315 | 32 | 40 | 4 | 693 | 65 | 30 | 3 | 1058 | 37 | 31 | 1 |
| | | | | | | | | 1063 | 76 | 73 | 5 |
| | | | | | | | | 1073 | 26 | 46 | 10 |
| | | | | | | | | 1074 | 43 | 56 | 1 |

interspersed, and as the diet is gradually built up, every patient's program includes one day of partial fasting or reduced diet every week. One result of this regime is a loss of weight, which is sometimes masked by water retention at first, but becomes evident later. Some gain of weight may be permitted later if the tolerance warrants, but as a general rule the assimilation varies inversely with the weight, and the weight is, therefore, kept low, as the means of maintaining a satisfactory tolerance. Tables III and IV show the weights of children and adults, respectively, in this series of cases at admission and at the conclusion of treatment. The weight at admission furnishes one of the most important criteria regarding the severity, which, in general, was of high degree in this series of cases. The change in weight, under treatment, shows the extent of undernutrition required to control the diabetes and to build up tolerance for a living diet. It, therefore, serves as an additional index of severity, and it will be noticed that some patients had to be reduced by thirty pounds or more. At the same time it must be emphasized that there was generally a gain in strength and comfort to a degree which was clearly perceptible to the patients, and which encouraged the majority of them to remain faithful to their diets.

More or less prejudice has been aroused by the name "starvation treatment," and it seems necessary to repeat two facts regarding these diets. First, they represent undernutrition, in the sense that the patient's body weight is kept permanently below the original level and generally below the level at the time of his admission. In cases of obesity, this may mean merely a reduction of the quantity of surplus fat, leaving the absolute weight at, or only slightly below (in some mild cases actually a little above) the normal standard for that height. With increasing degrees of emaciation at entrance, and with increasing severity of diabetes, more advanced grades of undernutrition are required for the control of symptoms. As above mentioned, we have not hesitated to carry this regime to any point needed for this purpose, in the belief that both life and comfort are thus conserved. The main point is that the old idea of the desirability of building

up the body weight in diabetes is absolutely rejected, and the hope of controlling symptoms and preventing downward progress is based upon the principle of holding the patient's weight merely at the best level which is permitted by his diabetes. It is unfortunate when severe diabetes requires a severe reduction of weight and strength, for the attainment of any lasting control, but two facts may be pointed out. First, thorough treatment of mild or early cases is possible without such harsh measures, and this is the proper stage for such treatment, not only for the sake of the best immediate results, but also for the avoidance of progress downward into the severe stage. Second, it is hardly fair for opponents of undernutrition to argue as though severely diabetic patients had not always been thin and weak, or as though they possessed any magic formula for keeping them plump and strong, or as though the old-time plan of high-calory diets for the sake of temporary nutrition and satiety had not proved so disastrous that a reversal of it promptly won the support both of diabetic patients and of the general medical profession.

The second point may be more surprising, namely that these diets are actually higher than the opponents of undernutrition have ever been able to use while keeping glycosuria absent in cases of similar type. It is only necessary to have agreement that diabetics are better off when they can be maintained in nutritive equilibrium on some diet which keeps symptoms absent. Granting this one premise, examples may be taken from cases not uncommonly seen in consultation, when a specialist may say: "This patient has a tolerance for only thirty grams of protein and 500 calories per day, without carbohydrate. If he is kept on this diet, he will starve to death, and if the diet is raised, glycosuria and acidosis will soon bring on coma." As a matter of fact, many diabetics have wasted away on such a regime, the diet being reduced when coma threatened, then raised in the attempt to restore strength, and this alternation continued to death, from either inanition or coma. As a contrast, it will be noticed that in even the severest cases of this series completion of treatment has almost always resulted in

tolerance for a diet of thirty calories per kilogram of weight. In cases like the example cited, rigid initial undernutrition accomplishes three things, besides abolishing glycosuria and hyperglycemia. First, it lowers the body weight, so that the same absolute ration comes to represent a larger ration per kilogram. Second, it markedly lowers the caloric requirement, as calculated for the surface area by the old Meeh or the new height-weight formula⁸, and this reduction of metabolism allows the maintenance of equilibrium on a lower absolute ration. Third, it raises the tolerance, so that a higher absolute diet can be taken while preserving the freedom from acidosis and hyperglycemia. Very few cases, therefore, are incapable of reaching an equilibrium, and this combination of events was summarized in the previously published statement⁹ that "almost always the curve of rising tolerance intersects the curve of falling weight at a level on which life can be maintained." As downward progress in assimilation is also thus checked to the greatest possible extent, it follows that the nutritive equilibrium thus established can be maintained either indefinitely or for a longer time than on any other plan, and this fact supports the conclusion that both life and comfort are longest preserved in this way.

Joslin has mentioned in his textbook the practical disappearance of acutely fatal diabetes and the diminishing number of deaths within the first year of diabetes. It is illuminating to make comparison with figures given by Naunyn¹⁰. He quotes statistics of Griesinger and Pfeiffer, published in 1875, for 152 diabetics of all ages. Of these, 2 died within three months from the time of onset, 15 within six months, 30 within one year, 47 within two years, 31 within three years, and 12 within four years, while the remaining 15 patients lived from five to fourteen years. Naunyn considered these figures too unfavorable, and, therefore, gave the results of 141 cases at all ages from his own private practice. In his series, 42 patients died in the first year of their diabetes, 35 in the second year, 23 in the third year, 14 in the fourth year, 5 in the fifth year, and the remaining 22 at longer intervals. These figures deserve the attention of persons who question whether the treatment of diabetes has im-

proved, for few writers in this country today would care to confess to such results.

There are still many physicians who hold, either openly or tactily, that diabetic patients, especially of the more severe type, should not be subjected to very rigorous privations, but should be fed with a view to the greatest possible comfort, even though their lives be somewhat shortened. It need only be remarked that this view is contrary to the belief of the recognized specialists in the subject, who are convinced that the patients under suitable dietary control, even when this must be very vigorous, not only live longer, but also preserve greater comfort and usefulness than those whose symptoms are allowed to continue. Also, as the recent changes in diabetic treatment in this country have consisted essentially in stricter limitation of fat and total calories, it was inevitable that there should be a reaction, which now makes itself felt in the form of a strong movement toward a resumption of diets high in fat and calories, with a view to avoiding the undernutrition, which some of us consider the essential feature in diabetic treatment.

Genuinely high fat diets, with low protein and carbohydrate, have been used in Europe by Naunyn and all his followers in the management of severe cases, and one-sided diets of this character have been advocated since 1914 by Petren¹¹, as a general treatment for diabetes, on the ground that protein is specifically injurious, while fat in any quantities is harmless. Petren has supported his views with abundant statistics which, however, show his results to be inferior to those obtained by most persons who treat diabetes in this country. The statements of Maignon¹² have attracted some recent notice in this country, though his theoretical views on acidosis are contrary to existing scientific knowledge on the subject, and his clinical experience cannot be judged until it is expressed in definite facts and figures. As there are no indications that Maignon follows even the elementary rules of weighed diets for his patients, it need not be seriously supposed that his results in severe cases support his vague claims of success or compare with the standards recognized in this country.

The recent publications of Newburgh and Marsh¹³ have been widely misunderstood, inasmuch as they advocate diets which are only relatively high in fat in proportion to the low protein and carbohydrate, and restriction of total calories is actually employed by them in a degree corresponding to the severity of the case. For example, in milder cases their diets, as published, seldom exceed 2,500 calories, and in a severe case the ultimate diet may be below 1,500 calories. Much harm will be done if physicians at large gain the impression that the work of Newburgh and Marsh demonstrates the harmlessness of unlimited use of fat. The broader principles of dietary management, including restriction of total calories and the necessity of undernutrition, especially in severe cases, are agreed upon by all recognized American specialists. The discussion is still open concerning the exact degree of such undernutrition and the exact proportion of food materials, which are most beneficial in the long run. This matter can be settled partly by animal experiments, which many clinicians are too prone to ignore, and partly by clinical statistics collected accurately over a sufficient number of years. The published figures of Newburgh and Marsh, from 1918 to 1922¹⁴, show a mortality of 14 per cent. Their cases on the whole have been mild, as indicated by the advanced age of the majority of patients, the good nutrition of the younger patients at admission, and the high tolerance which was quickly attainable in the group as a whole. Under these circumstances, the results seem distinctly inferior to those of Joslin and also those of the Physiatrie Institute, which were obtained with a plan of stricter limitation of fat intake, total calories and body weight. There is no record that advocates of high fat diets have ever succeeded in fattening a single patient with genuinely severe diabetes. Our own experiences with attempts to overnourish diabetic patients with fat or any other kind of food have been disastrous, as recorded in former publications. Patients have been thin and weak in proportion to the severity of their diabetes under every form of treatment yet known in the world, and we are convinced that under the principle of sparing a weakened function, symptoms are prevented, downward

progress checked, and both strength and nutrition are better maintained than under any plan of forced diets.

In summary, it may justly be claimed that the results of diabetic treatment have improved with the use of undernutrition. The benefit may be stated as two-fold: First, life has been prolonged. Joslin¹⁵ has recently computed that diabetics in Boston are living two years longer on the average than under former methods of treatment, and that this result applied to the million diabetics of this country would mean a gain of two million years of human life. This is the result achieved by the imperfect application of the newer methods among the medical profession at large, and which can admittedly be improved much farther as these methods are more efficiently employed. Many elements enter into this improvement, including advances in chemical methods, earlier diagnoses and growing knowledge of diets on the part of physicians and patients, but the possibilities open are obvious. Second, patients live not only longer, but also more comfortably. As already mentioned, undernutrition by means of suitable limitation of all classes of food paradoxically maintains strength, nutrition and usefulness better than any other method. A further very important element is the complete avoidance of the so-called complications of diabetes. Gangrene, carbuncle, cataract, retinitis, neuritis and the long list of distressing ailments which occupied so much space in the classical textbooks of diabetes are practically non-existent under thorough modern treatment. This one point of safety from complications is worth all the privations involved in any form of diet.

It was mentioned at the outset that diabetes, like the whole subject of metabolism, is a rapidly growing and developing field. Scarcely a year now passes without some important contribution. The outstanding achievement of recent times and one of the greatest discoveries of all modern medicine is the preparation of an extract containing the internal secretion of the pancreas in a practically non-toxic form, which appears to have been accomplished by the group of investigators who have recently announced their discovery in Toronto¹⁶. A great problem has thus been solved and the way has been

opened for further important researches. A product of this character can scarcely fail to find practical usefulness, and we may hope, especially, that it may prove of aid in acute crises, such as coma, and for enlarging diets in the severe cases, which are now close to a starvation basis. On the other hand, these expectations of practical usefulness should not be exaggerated. The information to date is that the new-found insulin is comparable to certain other hormones, such as epinephrin and pituitrin, first, in being powerful but brief in its action, the effects of a single dose passing off within a few hours, and second, in being effective only when given by parenteral injection, and useless when given by mouth. Unless this difficulty can be overcome the clinical application of the new product must be limited, and diet will still remain the fundamental basis of treatment for diabetes. In other words, this discovery appears to represent an extremely important advance step, but the actual cure of diabetes is still in the future.

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DISCUSSION

Dr. Martin J. Synnott, Montclair: In the discussion of this admirable paper, the point I wish to emphasize is that diabetes, like most chronic ailments, is the result of a preceding infectious process; either the vestigium of an "old burnt out conflagration" of Allen, following a pneumonia, a scarlet fever or a diphtheria, or a hematogenous infection from teeth or tonsils, or an extending duct infection from duodenitis or an achylia gastrica. In every case of diabetes, therefore, that comes to us, a systematic attempt must be made to locate all focal lesions, whether in the teeth, sinuses, tonsils, stomach, gall bladder, appendix or colon, and to eliminate them, if the patient is to be cured. This can be done only by a thorough and painstaking physical examination, with a roentgen study in many cases, and necessary laboratory tests, including the Wassermann reaction. Blood chemistry is absolutely necessary in the scientific management of diabetic patients, and our efforts must be directed toward maintaining the plasma sugar at a safe level. It is not enough to keep the urine sugar free, as many diabetics may be doing badly without showing glycosuria. Then, too, there are certain abese individuals who come to us, often complaining of neuritis or neuralgia, usually with a lowered blood pressure. Many of these individuals are in Allen's class of "potential diabetics." They may have normal urine, and the condition may be diagnosed only by blood chemistry, which shows a much increased plasma sugar.

Until recently the only available plan of treating diabetes has been by diet. Of the various methods employed I think the most satisfactory one has been the low calory diet of Allen. This has its disadvantages in that the patients treated, according to it, are often hungry, weak and dissatisfied, but on the other hand there is no doubt that it does prolong life. And most patients prefer to have their existence here prolonged, even at the expense of their craving for food. Recently a series of investigations were undertaken by Dr. H. S. Martland, of Newark; Dr. J. J. Selman, of the Physiatrie Institute, at Morristown, and myself, to determine just how important a part ascending duct infections extending into the pancreas, play in the etiology of diabetes. Our studies, which have been published and which included fifty-three diabetic cases, showed an appreciable number of patients with evidences of existing duodenobiliary infection, who also gave a history of previous affections of the biliary or upper right abdominal regions. The Lyon method of drainage is the only

available non-surgical diagnostic procedure to determine directly whether or not the biliary system is infected. Where infection is shown to be present, this method, along with inoculations by an autogenous vaccine, offers a mode of therapy, which should not be neglected. We have all been interested in the published reports of the work by Dr. MacLeod and his associates, of Toronto, to which Dr. Allen has referred. They have undertaken the isolation of a ferment from the pancreas of dogs, which, when injected hypodermically into patients, will supply the internal secretion of the Islands of Langerhans, which is known to be deficient in diabetic patients. This substance, which Dr. MacLeod calls "insulin," is said to cause the rapid disappearance of diabetic symptoms. It is a hopeful field of investigation and practical good may eventually come from it.

Dr. David F. Weeks, Skillman: I have been very much interested in this paper, and the good work that Dr. Allen is doing at the Physiatrie Institute and elsewhere. It has been my privilege to have Dr. Allen co-operate with us at the village in the study of metabolism in epilepsy, the results of which study will soon be published. In my association with Dr. Allen, I have been impressed with certain things about the study and treatment of diabetes. One of the most important things we do not want to lose sight of is the importance of the inherited factor in this disease. It is the practice of Dr. Allen to take blood specimens from other members of the family of a case coming under his care; in this way he detects many potential diabetics. It seems to me that the profession should recognize the importance of taking these blood specimens from their patients and members of their families. The importance of so doing was particularly emphasized in a recent examination in a family where the youngest child showed great need for care in the direction of diet. This early discovery of tendency to diabetes will put the child under intelligent direction and treatment, and probably prevent the development of this disease in her case. Another fact to be borne in mind when patients become careless in their diet, is that they will almost invariably become interested in the progress of their treatment if required to keep a daily record of their weight, which they must be encouraged to keep, slightly under standard for their age and weight.

Dr. David C. English, New Brunswick: I do not rise for the purpose of discussing the treatment of diabetes, but I want to say that I regard it as one of the most pleasant things at this session of our Society to have had Dr. Allen with us to give this splendid talk on diabetes. Two years ago the Physiatrie Institute was opened with public exercises. Dr. Allen did me the great honor of inviting me to attend as the representative of the Medical Society of New Jersey on that occasion. Our President, at that time, Dr. Harris, had been invited to speak for the State Society, but he could not be present. Serious illness in my family that day prevented me from attending, but I sent a letter, which was read, presenting my own sentiments and, as I be-

lieved, the sentiments of the members of the Medical Society of New Jersey, in reference to the great work that the institute was organized to carry on. It has been my privilege to visit the Physiatrie Institute two or three times since, and to attend a clinic held there, and I was pleased, more than I can express, to find that the optimistic sentiments that I expressed in the letter referred to concerning the institution's future had been more than verified. I had spoken of the institute as being an honor to the State of New Jersey, and that it gave us, as a Society, pleasure to have such a splendid institution within the boundaries of our State. We have been glad to welcome Dr. Allen to the State of New Jersey and into membership in the Medical Society of New Jersey, and I believe I express not only my own, but also the Society's sentiments in congratulating him on the splendid work that he is doing in that institute. In the clinic that I attended the result of the work there, as shown by the record of a large number of patients who appeared at the clinic were, to my mind, simply marvelous, and I again express my belief and I am quite confident the belief of the medical profession generally that the State has been honored by the establishment of that institution within its borders.

Dr. Frederick M. Allen, Morristown, closing: The cases of women with glycosuria are of a type commonly encountered. I have seen such conditions continue for as long as thirty years.

Question—"Were the Islands of Langerhans involved?"

Dr. Allen: Yes, I think so. The question of distinction between different types of diabetes was apparently settled by the classical writers whose careful clinical studies showed every grade of transition between the mildest and severest forms. The mild and severe types may not only occur in the same family, but also the progress of cases from the mild to the severe stage is well known. Especially in middle or later life diabetes may, as stated, continue for a number of years without apparent harm, and during this stage it is frequently diagnosed as a simple glycosuria. In the vast majority of instances it progresses from this mild stage into a more severe type which everyone recognizes as true diabetes. It is important to realize that diabetes is most dreaded in the young, because of its usual severity and rapid course; nevertheless, the older patients furnish by far the greatest mortality. This is because their milder forms of glycosuria are so commonly ignored or half-treated until they gradually pass into the dangerous stage or until gangrene, carbuncle, or some other preventable accident causes death. Diabetes is comparatively rare in the young. The great majority of cases occur in middle or later life, and in this group the largest opportunity for reduction of mortality is to be found, chiefly through the efforts of the general practitioner.

In regard to diabetes and tuberculosis, I would say that this is a very bad combination. We have no real hopes for any of our patients with this combination. The prognosis is doubtless fatal for all cases in which either

the tuberculosis or the diabetes is at all severe. This does not mean that nothing can be done, or that diet treatment is useless. When both the diabetes and tuberculosis are sufficiently mild, it is possible that skillful treatment of the two conditions may prolong life indefinitely. In the more advanced stages, there is no doubt that the tuberculosis advances most rapidly when glycosuria is present and when the diabetes is ignored in a mistaken attempt to overnourish for the sake of the tuberculosis.

Results are best when glycosuria is kept absent, even if this result is accomplished at the price of undernutrition. On the other hand, we do not try to maintain normal blood sugar with this complication. Even in severe cases a very appreciable prolongation of life and comfort can be achieved by careful diet, and as the cases are fairly numerous, there should be tuberculosis sanatoriums equipped with facilities and personnel for providing accurate diabetic diets. The greatest hope of all is that careful treatment of diabetes will prevent many tuberculous infections.

I purposely left out some important points for the sake of brevity, especially as I knew that Dr. Synnott would take up some of them. He has recently been studying gall-bladder infections, and such infections may be responsible for some cases of diabetes. If so, by proper treatment of the gall-bladder we are aiming at the primary cause of the diabetes. Blood chemistry represents one of the great modern developments in metabolism. Blood sugar analyses once every week or two are actually easier than the old fashioned plan of urinalysis every day or two, and they also furnish a more accurate guide of treatment. The use of accurate diets is the other great forward step. I think we have little to learn from Europe in this respect, and it will be noticed that European writers generally confine themselves to vague statements of results and do not publish their complete clinical statistics. The better treatment of diabetes in America as compared with Europe nowadays, consists in the wider use of exact rations of carbohydrate, protein and calories by physicians and patients in this country.

With regard to the Physiatrix Institute, I am thankful for the co-operation and good will shown by the medical profession of New Jersey. We are trying to have this as an institution which can conduct research in this subject, and also care for worthy charity cases. The support is derived from those who I think should support such an institution, viz.: the patients who have the necessary means to pay fees or make gifts. Whether or not the Institute succeeds in accomplishing anything deserving of the praise which Dr. English has so lavishly bestowed, I want the profession to feel that we are at least trying to do honest work. There is a need for this work in this subject, and if we can establish a reputation for honesty and right-dealing and have the continued friendship of our medical neighbors, we shall be satisfied.

A man can sleep peacefully when his wife groans. But he gets terribly worried when his automobile engine squeaks.—Cincinnati Engineer.

FOREIGN BODIES IN THE AIR AND FOOD PASSAGES.*

Henry Boylan Orton, M. D., F. A. C. S.
Newark, N. J.

The art of peroral endoscopy, in the removal of foreign bodies from the air and food passages, has been demonstrated by many bronchoscopist, and masterfully perfected by the father of American bronchoscopy, Professor Chevalier Jackson.

In the resume of my cases, two essentials stand out prominently. First, the need of careful preliminary examination of all suspected foreign body cases. Secondly, keeping in mind the history of the case, which will determine exactly what course to pursue.

I think it was the elder Gross, who classified foreign bodies into two groups. In the first group were those that were coughed up and got well. In the second group were those that came to autopsy. Such a classification, as you all are aware of, is obsolete. Nowadays any foreign body that has been swallowed or aspirated can be brought back in the same way.

The tendency of infants and small children to place things in their mouths is well known. Carelessness in both preparing and the eating of food is the cause of many cases. The failure to avoid a large bolus of food was the cause of complete obstruction of the esophagus in three instances, due to food lodging at the site of a stricture. The stricture known to exist by the patients.

The butcher in cutting meats should not splinter bones, and if bones are splintered the cook should see that they are not served in the food. Pins should not be in flour in the making of bread or rolls. I have removed pins from the esophagus in two such cases. The breast bones of chicken are not mentioned in the recipe for "chicken a la king," yet it has been served with unpleasant memories in a number of cases. To drink a glass of beer may be perfectly proper, if you could obtain it, but there is no need of swallowing the metal cap from the bottle, unless it were to destroy evidence. To have a child fourteen months of age assist in tacking carpet is wrong,

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as well as to place pins within reach of infants, when changing them is carelessness on the part of the attendant. The failure to diagnose has been the cause of unnecessary suffering in a certain number, and nobody should think of giving children under one year of age peanuts, eggshells or chicken bones to intake.

The symptoms in the laryngeal cases elicited were choking, croupy cough, wheezing, cyanosis, hearseness, dyspnea, vomiting and aphonia. The subjective symptom of pain in the neck was noted in a few.

Two cases in this group are worthy of note. One that of an open safety pin that had been in the larynx for eight months, the case had been treated for diphtheria and antitoxin given wisely. The child not improving after eight months was sent to the clinic by the family physician for the removal of the tonsils. In this case, gentlemen, an x-ray had been taken on the day of the aspiration of the pin, and the report came back to the doctor as negative. No laryngeal examination of the child had been made. Had a proper roentgenogram been taken and a direct or indirect examination of the larynx been made, the child would not have carried the foreign body in her larynx for eight months. To have given ether to that child with the foreign body in the larynx, plus the granulations, would have been fatal.

Another case where finger manipulation made a difficult case out of a simple one, for I cannot conceive how any man could inhale half of a lower dental plate without some help.

In the broncheal cases the symptoms, in order of frequency, were: Choking, cyanosis, cough, spasmodic cough, wheeze, tracheo-bronchitis, vomiting, hoarseness, temperature and a symptomless interval. In this group of cases I wish to give credit to Dr. E. W. Sprague for localizing a chestnut kernel in the right stem bronchus by physical signs, and to Dr. Ambrose Dowd for localizing by physical signs a piece of a filbert nutshell in the right bronchus. Their findings verified by bronchoscopic removal.

In the esophageal case, choking or gagging, dysphagia, vomiting regurgitation, cough, cyanosis, hematemesis, dyspnea and the subjective symptom of

pain in the neck and chest. There are other symptoms, but in the main, the above mentioned were most prominent.

The question now arises: "What are we going to do with a case that comes into the office with a history of swallowing or aspirating a foreign body?" 1. Get a complete history of the case, with a sample of the foreign body, if possible. 2. General physical examination, which includes the examination of the nose and throat, and a mirror examination of the larynx and pyriform sinuses. 3. Fleuroscopy. 4. Fleuroscopy, with opaque mixture and capsule. 5. Roentgenogram of the antero-posterior and lateral positions. 6. Laryngoscopy, bronchoscopy or esophagoscopy by the endoscopist.

Diagnosis.—The roentgen ray is the most valuable diagnostic means we have, but a careful examination should be made in all cases. The ray of the chest should be taken at the end of full expiration, and the roentgenologist must report the presence or absence of aneurysm. Although it is not a contraindication for the removal of foreign bodies, it is well to know before endoscopy that an aneurysm exists. If the ray is negative, but symptoms indicate broncheal obstruction, a diagnostic bronchoscopy should be done. In the esophageal case first without, then, if necessary, with a capsule filled with barium. Flat objects, as coins, lie with their greatest diameter in the coronal plane, when in the esophagus, and in the sagittal plane, when in the larynx.

The location of the foreign bodies were as follows: Left bronchus, 1; right bronchus, 2; left lower bronchus, 2; external branch right stem bronchus, 1; larynx, 4; larynx subglottic, 2; right stem bronchus, 1; below the cricopharyngeus muscle, 15; 14cm from the teeth in the esophagus, 1; 15 cm from the teeth in the esophagus, 2; 27cm from the teeth in the esophagus, 1; 35cm from the teeth in the esophagus, 1; hypo-pharynx, 4; at the thoracic opening in the esophagus, 4; at the aorta in the esophagus, 1; in the pyriform sinus, 3; total, 45.

Anesthesia.—Local or general was used only in three cases. In these three ether was the one used. One to get complete relaxation of the esophagus in the removal of a dental plate, to prevent trauma to the esophageal wall. Another in a very unruly foreigner, with com-

plete obstruction of the esophagus, due to a bolus of meat lodging at the site of stricture. This man resisted all attempts at the introduction of the esophagoscope. The third one, a very early case, for the removal of a coin. All others were removed without any anesthesia. The time necessary for the removal of the foreign bodies ranged from three seconds to one-half hour.

Extraction and cure in all but four cases. The first case, that of a pin in the bronchus, which I failed to remove, but was removed by Dr. Yankauer. I did not have proper forceps. The second case, a beer bottle cap was stripped off of my forceps, as I was coming out of the esophagus, it was passed by rectum four days later. One of the unfortunate accidents of esophagoscopy. The third case, a small open safety pin, passed into the stomach, the passage of the pin was watched by repeated x-ray, and when the pin remained in the same position for thirty-six hours it was removed by Dr. Haggerty by ileotomy. The pin had just perforated the small intestine. The child made a good recovery from the operation, but died six weeks later from a broncho-pneumonia. This brings up the question of how long should we wait before operating in a case where the foreign body (sharp) has passed into the stomach and intestine. The fourth case, that of a catch from a Robertson tonsil forceps, which broke off during an operation. I was called to do a bronchoscopy, and on my second attempt I grasped the foreign body, but it was caught on a branch bronchus, and not wishing to rupture the bronchus, I decided to try again in a week or ten days. The parents of the child were anxious, and they wanted another man. I didn't blame them in the least. So we suggested Dr. Jackson, and he, with his usual dexterity, removed it by fleuroscopic bronchoscopy.

The classifications of the foreign bodies were as follows: Glass bead, 1; pins, 7; metals, 2; intubation tubes, 2; artificial dentures, 2; tack, 1; coins, 7; nutshell, 1; eggshell, 1; meat, 3; seeds, 2; nut kernel, 1; bones, 13; tooth brush bristles, 2.

Recapitulation.—Do not give castor oil or any purgative in a foreign body case. Do not put your finger in the mouth and try to feel for the foreign body.

Do not disturb the patients any more than is necessary.

Do not fail to have repeated fleuroscopic examinations made to watch the progress of the case.

Do not take for granted that because you do not see it, and the x-ray does not show one, that there is no foreign body present. I removed foreign bodies from the esophagus in eight such cases.

Do not fail to use the laryngeal mirror, and if you cannot see it with the mirror, you cannot feel it with your finger without doing harm.

Do not fail to have them x-rayed by a competent man.

Don't pass coin catchers or bougees, they are dangerous.

Do not change the diet in a case that has passed into the stomach.

Occasionally we hear the expression: "Never Mind It," with esophageal symptoms. It is wrong. We have no more right to ignore the symptoms without an esophageal examination than you have to treat a case of appendicitis without making a local examination.

Until recently men looked upon the examination of the esophagus as a fussy pretension bordering on quackery.

External esophagotomy is not a justifiable operation, except in very rare cases, as was demonstrated by Dr. Jackson before the American Bronchoscopic Society in Washington this last May.

I wish to take this opportunity to express my thanks to Dr. H. C. Barkhorn for his valuable assistance, thereby making possible the successful removal of these foreign body cases.

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DISCUSSION.

Dr. Chevalier Jackson, Philadelphia: Before taking up the subject of the paper, I should like to say a word or two about how gratified I feel at the attendance of this Society, and especially that its members brought their wives with them. It seems to me the society has a good way of holding a State meeting.

Regarding the paper, I wish, to begin with, to compliment Dr. Orton on the splendid way in which he has presented this very interesting subject. And it is interesting, not only to him and to me, who do the work, but to every man

who practices medicine or surgery. I might go further, indeed, and say that it is interesting to the ladies present, even those who are not physicians, and I have a word to say to them, particularly, in regard to prophylaxis. I feel that if all the mothers in the land knew how dangerous it was for children to put coins in their mouths, Dr. Orton would not have so many to remove. Safety pins are also very dangerous. In changing the clothes of infants, these pins are often left within reach of the infant. They are bright and sparkling, attracting the infant's attention, and he often puts them into his mouth. When it comes to prophylaxis, the only thing that the doctor can do is to preach to the mother, the trained nurses, and the nursery maid, the gospel of prophylaxis, which is better than cure, even by the brilliant bronchoscopic removals that Dr. Orton has performed. I said in the beginning that this is a subject interesting to every practitioner. For too long a time, foreign bodies in the air and food passages were regarded as one of the curiosities of medicine; whereas they really are every day diagnostic possibilities for exclusion, in every acute or chronic chest case. I only need to pick out a few of the many cases that Dr. Orton has reported to illustrate that point.

Take that case of the safety pin: the child was croupy; the inference was that it had laryngeal diphtheria, but there was no membrane in the fauces. The profession does not know that the larynx of any child, from the day it is born, can be examined directly by means of the direct laryngoscope. You cannot look at the larynx of any child, from the look at the larynx with the mirror until the child is about five years old. That case of overlooked laryngeal foreign body is not an isolated one, by any means. A child without membrane in the fauces has a croupy cough, and is given antitoxin. It is right to give the antitoxin. No one should be criticised for that. But the larynx of every child with a croupy cough should be examined directly, unless a positive diagnosis of diphtheria in the fauces is made; then if the child has a cough, the inference is justified that the laryngeal condition is also diphtheria, and direct examination is not called for; but in every other case it is called for. In regard to the case in which Dr. Orton and I worked together, the surgeon had lost a portion of his instrument in doing a tonsillectomy. It required three bronchoscopies to remove the foreign body, and it fell to my lot to do the third. I was called into the case because the relatives were getting a little troublesome. The surgical accident was not the fault of the surgeon, who did not make the instrument. "True as steel," is a poor simile; there are few materials so unreliable as steel, which will break when least expected, and no amount of preliminary inspection can prevent it. I was called into the case to bear part of the responsibility. As far as skill was concerned, I was not needed, as Dr. Orton would have removed the foreign body had he done the third bronchoscope. There is another interesting point in this case. We must all admire and profit by the noble example of the surgeon who promptly urged a ray examination to locate the missing part of the instrument. Whenever it happens that any portion of an

instrument is lost anywhere in the anatomy—for instance, if a hypodermic needle breaks we should tell the patient promptly, and immediately have an x-ray made to determine the location of the lost piece of the instrument. Then we should call in consultation someone who can help to do what is necessary. This is not only morally right, but it is an absolute protection against trouble. While the foreign body may be in the intestine and pass on, we must not take for granted; but have the roentgenray and physical examination made and the stools watched. I have seen a good many cases where hypodermic needles and portions of instruments, surgical and dental, have been lost, and always from the hands of the most skilful people.

Another matter that Dr. Orton brought up is the question of how long we should wait in the case of a foreign body in the intestine. There was a time when I felt sure of my ground, but I have had to modify it. A foreign body that has reached the stomach will pass naturally in probably ninety-nine out of a hundred cases; but Dr. Orton has shown that you must not be certain what it will do. We should watch the patient regularly with the fluoroscope until the foreign body is recovered from the stools or disappears. Open safety pins have passed through the intestines without trouble; but if, at any point in the passage they lodge for a certain number of days, about four or five, Dr. Orton and I believe, it is a question whether operation should not be undertaken. If perforation occurs and infection takes place, you have a serious operation, whereas a clean operation is not serious. I had one case in which the safety pin was regurgitated into the esophagus, penetrating the esophageal wall and the pericardium. We removed the safety pin with the esophoscope, and the child is well; but it might have died from mediastinitis. In another case, Dr. Manges manipulated the intestines through the abdominal wall, and under fluoroscopic guidance and dislodged the safety pin from where it seemed to be caught in the folds of the descending colon and the pin passed out in the stools. This procedure is not free from danger; but, in the hands of an expert like Dr. Manges, it should be attempted.

With regard to external esophagotomy, Dr. Orton thinks that it is an unjustifiable operation. He referred to some remarks of mine on the subject at the meeting of the American Bronchoscopic Society this year. These remarks were based on over fifteen hundred cases of foreign body in the esophagus removed esophageally, not by me, but by the members of the Society, including Dr. Orton. Of the fifteen hundred cases, there were only, if I recall rightly, but six that were removed by external esophagotomy; and the men thought that these six could also have been removed by esophagoscopy in its present day development. Contrast with this record, a report I saw in the Journal of the American Medical Association. A surgeon in Leipzig had thirteen cases of foreign body in the esophagus. He tried the esophagoscope, without having had previous experience with the instrument, and failed. He did external esophagotomy, having almost fifty per cent. mortality, and he concluded by condemning

| Case No. | Age | Foreign Body | Location | Anes-thesia | Tube | Problem | Forcep | Point of Seizure | Result | Time | Route | Remarks |
|----------|---------|---------------------------------------|--|-------------|--|--|--------------|--|--|---------------------|-------|---|
| 1714 | 6 | Glass bead. | Right Bronchus. | None | 5mm Bronchoscope. | To grasp smooth body. | Rotation | One blade passed in opening of bead. | Extraction and cure | 6 minutes | Oral | Child passed penny per rectum next morning. |
| 1002 | 21 mos. | Common pin. | Left lower bronchus. | None | 5mm Bruening tube. | Protect point. | Bruening | Point | Extraction and cure. | 2 minutes | Oral | Removed by Dr. Yankaner. |
| 1508 | 7 | Catch from Robertson's Tonsil Forcep. | External branch of right stem bronchus | None | 5mm Bronchoscope. | To grasp presenting point and prevent catching. | Angular | Presenting point. | Extraction and cure. | 24 min., 16 seconds | Oral | Removed by Dr. Jackson of Philadelphia. Fluoroscopy. |
| 1240 | 6 | Open safety pin.] | Larynx, below cords keeper on level with cords, 8 months. | None | Jackson's child's laryngoscope. | Impacted point in subglottic tissue. | Mathews. | Keeper. | Extraction and cure. | 20 seconds | Oral | Disengagement of point downward turned to median line. |
| 1762 | 6 | Intubation tube | Larynx, subglottic. | None | Child's laryngeal speculum. | To grasp foreign body through considerable edema and granulations. | Straight | One point of blade within the tube one pt. outside. | Extraction and cure. | 10 minutes | Oral | Considerable edema and absence of forcep space made it difficult to remove. |
| 1761 | 4 | Intubation tube. | Larynx, subglottic. | None | Child's laryngeal speculum. | To grasp foreign body through an edematous and granulating supra-glottic structures. | Straight | One point of blade within the tube, one pt. outside. | Extraction and cure. | 2 minutes | Oral | Evidently in extubating the tube had been forced below the cords, some amount of trauma caused by former attempts at removal. |
| 1470 | 83 | One-half lower dental plate. | Larynx | None | Adult laryngoscope. | None | Alligator | Presenting part of plate. | Extraction and cure | 1 minute | Oral | Pharynx and hypo-pharynx traumatized by previous attempts to remove with finger, half plate being pushed in larynx. |
| 1445 | 19 mos. | Egg shell, 36 hrs. | Larynx, between cords. | None | Child's laryngoscope. | Prevent the shell being aspirated. | Alligator | Flatwise | Extraction and cure. | 10 minutes | Oral | Respiratory blast removed shell from view, 5mm bronchoscope passed exploring trachea, right and left bronchus F. B. not seen, removing tube, F. B. expectorated from mouth. |
| 1793 | 13 mos. | Chicken bone. | Left bronchus. | None | 4mm Bronchoscope. | Protecting sharp edges. | Side curved. | Presenting point. | Extraction and cure. | 4 minutes | Oral | First lodged in subglottic space, dislodged and removed from left bronchus, subglottic edema following day. |
| 1457 | 7 yrs. | Piece of filbert nut shell, 36 hrs. | Right main bronchus. | None | 7mm Bronchoscope. | Foreign body withdrawn in axis of larynx. | Side curved | Flatwise. | Extraction and cure. | 2 minutes | Oral | Diffuse bronchitis, trachea and bronchia filled with thick mucoid discharge. |
| 1723 | 7 mos. | Chestnut kernel. | Right stem bronchus, anterior branch. | None | 4mm Bronchoscope. | None | Straight | Presenting point. | Extraction and cure. | 6 minutes | Oral | Tracheo bronchitis, temperature dropping next day. |
| 1628 | 7 mos. | Open safety pin. | Esophagus, below crico pharyngeus muscle. | None | 7m Esophagoscope. | To protect point. | | | Tube wider than pin, pin dropped into stomach. | 10 minutes | Oral | 4 days later pin removed by ileotomy, good recovery; died 1 month later of broncho pneumonia. |
| 1553 | 6 | Nickel, 4 mos. | Esophagus, below crico pharyngeus muscle, 14cm from teeth. | None | Jackson's anterior commissural laryngoscope as esop. speculum. | None | Alligator | Flatwise. | Extraction and cure. | 15 seconds | Oral | Coin blackened by long stay in esophagus. |
| 1162 | 2 | Penny, 5 days. | Esophagus, below crico pharyngeus muscle. | None | Jackson's anterior commissural laryngoscope. | None | Alligator | Flatwise. | Extraction and cure. | 2 minutes | Oral | |
| 686 | 4 | Nickel | Esophagus, below crico pharyngeus muscle. | None | Esophageal speculum. | None | Straight | Flatwise. | Extraction and cure. | 4 minutes | Oral | |
| 1149 | 18 mos. | Nickel | Esophagus, below crico pharyngeus muscle. | None | Esophageal speculum. | None | Alligator | Flatwise | Extraction and cure. | 3 minutes | Oral | |
| 1198 | 8 mos. | Open safety pin. | Keeper caught in latter pharyngeal fold over chink of glottis. | None | Tongue depressor as direct speculum. | Prevent going down. | Straight | Presenting point. | Extraction and cure. | Less than 1 minute | Oral | Emergency, in making examination saw the condition. |
| 1407 | 10 mos. | Penny, two weeks. | Esophagus, below crico pharyngeus muscle. | None | Laryngoscope used as esophageal speculum. | None | Alligator | Flatwise. | Extraction and cure. | 15 seconds | Oral | No esophagitis, two previous attempts made by other doctors. |
| 1213 | 6 | Coins, two quarters | Esophagus, at thoracic opening. | None | Esophageal speculum. | None | Straight | Flatwise. | Extraction and cure. | 4 minutes | Oral | X-ray showing but one coin, two removed. |
| 1488 | 56 | Grape fruit seed. | At site of stricture 35cm from teeth. | None | 10mm Esophagoscope. | None | Side Curved | Flatwise. | Extraction and cure. | 2 minutes | Oral | At site of stricture grape fruit seed was found acting as a ball valve. |
| 1490 | 14 mos. | Carpet tack | Dorsal branch, left bronchus. | None | 4mm Bronchoscope. | To get in line of axis of trachea and bronchus. | Angular | Point of tack. | Extraction and cure. | 12 minutes | Oral | Tack had changed its position from last X-ray. |
| 1517 | 34 | Common pin | Esophagus, level 3rd, 4th and 5th cervical vertebra. | None | Jackson's esop. spec. | To disengage point. | Straight | Presenting point. | Extraction and cure. | 6 minutes | Oral | Two-thirds of pin imbedded in mucous membrane of esophagus, some swelling of neck. |
| 1270 | 52 | Chicken wing bone. | Esophagus, level of 6th cervical vertebrae. | None | Esophageal speculum. | Impacted point. | Straight | At pointed end. | Extraction and cure. | 4 minutes | Oral | Disengaged at point by lateral tubal pressure. |

| Case No. | Age | Foreign Body | Location | Anes-thesia | Tube | Problem | Forcep | Point of Seizure | Result | Time | Route | Remarks |
|----------|--------|---|---|-------------|---------------------------|---|-------------------------------|--------------------|----------------------|------------------|-------|---|
| 1478 | 11 | Bent pin | Esophagus, below crico-pharyngeus muscle. | None | Jackson's esop. spec. | Plates not showing pin same as found. | Alligator | Presenting point. | Extraction and cure. | 45 seconds | Oral | Posterior wall of pharynx lacerated. |
| 1435 | 10 mos | Open safety pin 2 days. | Esophagus, at point at crossing of aorta. | None | 7mm Esophagoscope. | Protecting the point. | Angular | Point | Extraction and cure. | 14 minutes | Oral | Just after point was disengaged patient stopped breathing. Bronchoscopy—4mm tube passed and oxygen given. Eso-phagoscope again passed. |
| 1694 | 43 | Piece of duck bone breast. | Esophagus, below crico-pharyngeus muscle. | None | Jackson's esop. spec. | None | Alligator | Flatwise. | Extraction and cure. | 15 seconds | Oral | Bone outlined by barium paste. |
| 1682 | 51 | Fish bone, fin. | Esophagus, below crico-pharyngeus muscle. | None | Esophageal speculum. | None | Alligator | Flatwise. | Extraction and cure. | 2 minutes | Oral | Bone outlined by barium paste, bone very difficult to see as it was the same color as the esophagus. |
| 1209 | 23 | Artificial denture rubber, 2 days | Esophagus, below crico-pharyngeus muscle. | Ether | Esophageal speculum. | To protect esophagus. | Rotation | At pointed end | Extraction and cure. | 8 minutes | Oral | Disengagement of point by lateral tubal counter pressure, ether necessary to relax esophagus to prevent trauma |
| 1659 | 53 | Beef steak. | Esophagus, at site of stricture, 24cm from teeth. | Ether | 10mmx53cm Esophago-scope. | Pulpous consistency. | Mechanical spoon and straight | Presenting parts. | Extraction and cure. | 30 minutes | Oral | Ether necessary in this case on account of stubbornness of patient. |
| 1555 | 51 | Chicken bone. | Esophagus, below crico-pharyngeus muscle. | None | Jackson's esop. spec. | None | Alligator | Extreme right end. | Extraction and cure. | 15 seconds | Oral | X-ray did not show bone. |
| 1459 | 63 | Piece lamb chop bone. | Esophagus, below crico-pharyngeus muscle. | None | Jackson's esop. spec. | None | Alligator | Flatwise | Extraction and cure. | 4 minutes | Oral | X-ray did not show bone. |
| 1519 | 5 | Beefsteak | Esophagus, at site of stricture. | None | 7mm Esophagoscope. | None | Mechanical spoon and straight | Preseuting parts. | Extraction and cure. | 3 minutes | Oral | Previous lye stricture. |
| 1544 | 51 | Fish bone | Left pyriform sinus. | None | Laryngoscope. | None | Alligator | Free point. | Extraction and cure. | 2 minutes | Oral | X-ray did not show bone. |
| 1734 | 36 | Piece of bone and meat from chicken breast. | Esophagus, below crico-pharyngeus muscle. | None | Esophageal speculum. | None | Straight | Flatwise. | Extraction and cure. | 2 minutes | Oral | Some esophagitis due to stay of foreign body. X-ray did not show bone. |
| 1829 | — | Chicken bone | Right pyriform sinus. | None | Esophageal speculum. | None | Alligator | Presenting point. | Extraction and cure. | 3 minutes | Oral | X-ray did not show bone. |
| 1339 | 38 | Bone from lamb. | Esophagus, below crico-pharyngeus muscle. | None | Esophageal speculum. | Impacted points. | Rotation | Pointed end. | Extraction and cure. | 3 minutes | Oral | X-ray did not show bone. |
| 1388 | 58 | Cap from beer bottle, 6 hrs. | Esophagus, level of cri-coid cartilage. | None | Esophageal speculum. | Protection of sharp edges | Alligator | Flatwise. | Extraction and cure. | 7 minutes | Oral | Cap grasped with forcep, speculum, forcep and cap all removed to crico-pharyngeus muscle, spasm occurred stripping cap off forcep, patient swallowed cap. |
| 1765 | 7 | Food, liver. | Esophagus, at crossing of bronchus. | None | Esophageal speculum | None | Straight | Presenting point. | Extraction and cure. | 15 minutes | Oral | Previously bouginaged for a lye stricture of esophagus, large bolus of food lodging at stricture. |
| 1764 | 71 | Fish bone. | Left pyriform sinus. | None | 7mm Esophagoscope. | None | Straight | Presenting point. | Extraction and cure. | 15 seconds | Oral | Removed by direct method. |
| 450 | 45 | Fish bone. | Across larynx above cords. | None | Laryngoscope. | To protect point and prevent going in larynx. | Straight | Presenting point. | Extraction and cure. | 18 seconds | Oral | Point of bone was imbedded in wall of larynx |
| 1879 | 39 | Chicken bone. | Esophagus, below crico-pharyngeus muscle. | None | Esophageal speculum | Protection of sharp points. | Straight | Presenting point. | Extraction and cure. | 8 seconds | Oral | Finger manipulation had been tried by other doctors as soon as esophagus was opened, pus came out. |
| 1890 | 1 | Penny, two days. | Esophagus, below crico-pharyngeus muscle. | None | Esophageal speculum. | None | Alligator | Flatwise. | Extraction and cure. | 8 seconds | Oral | Previously been tried by other doctor. |
| 499 | 23 | Peach stone. | Hypo-pharynx. | None | None | Prevent going down. | None | | Extraction and cure. | Less than minute | Oral | On examining throat indirectly, patient gagged and vomited peach stone. |
| 1372 | 42 | Tooth brush bristle. | Left tonsil. | None | None | None | Straight | Pointed end. | Extraction and cure. | 5 seconds | Oral | |
| 1828 | 41 | Tooth brush bristle. | Right tonsillar fossa. | None | None | None | Straight | Pointed end. | Extraction and cure. | 5 seconds | Oral | |

the esophagoscope. Contrast this with Dr. Orton's work, with no mortality at all.

In conclusion, I should like to compliment Drs. Sprague and Dowd on their diagnostic work; and I cannot speak too highly of the x-ray work that Dr. Orton has had done. I compliment Drs. Sprague and Dowd because of the difficulties in locating nonopaque foreign bodies, such as peanut kernels in the lungs. Having overlooked foreign bodies myself, I feel free to tell you of an experience I had when I went back home from Jefferson Medical to Pittsburgh, thirty-six years ago. I heard a practitioner, a very capable man, a rapid deductive thinker, and a great man for his time, say, "What is this about appendicitis I have been practising for forty years and never saw a case of appendicitis. Possibly some of those in practise who have not seen a case of arachidic, or peanut, bronchitis have overlooked one or more under some other diagnosis.

Dr. Henry C. Barkhorn, Newark: Dr. Orton is to be congratulated on making such a good showing in so short a time. It shows how intensive work can affect cases and results. During the last year there were admitted to the Presbyterian Hospital more cases than during all the years before. This is to the advantage of the hospital, and of our people working there. We feel that Dr. Orton has done something for the community and for the profession. The work is unremunerative and takes a large outlay for instruments, which are very fragile. Dr. Jackson can, of course, do miracles. He has taken a foreign body out through the bronchi, which went in through the ribs. Each case presents a difficult mechanical problem and must be worked out according to the age of the patient and to the nature of the body. Twenty-nine of the forty-five bodies were relatively high up, but this did not lessen the problem. The absence of mortality in Dr. Orton's statistics is noteworthy. Curiously enough, esophageal cases are more dangerous than bronchial, for the esophagus is more likely to perforate and produce septic mediastinitis, etc. A laryngeal case, with the tube in the trachea and bronchi, can always breathe. With the tube in the esophagus, the larynx is sometimes pressed on, and breathing shut off, so we have done more resuscitations in esophageal than in laryngeal cases.

This represents the smaller portion of Dr. Orton's work, although the more spectacular. In addition, he has done much research work in esophageal disease; and we, at the infirmary, feel very definitely that he should be encouraged in every way to develop the field. He is practically the only one in New Jersey doing it intensively, and these forty-five cases were seen in less than two years. In Newark we did not have forty-five cases in all the time prior to that in the history of laryngoscopy.

Dr. Hyman I. Goldstein, Camden: The bronchoscopist seems to remove the foreign bodies, and the x-ray man to locate them. It is, however, after all, men practising internal medicine, who get the people first. If we can diagnose the cases to the point where we can say: "There is a foreign body here," and refer the case to the bronchoscopist or

x-ray man, most cases can be saved; but if we delay too long, these gentlemen that we have with us might fail. I might mention here an excellent paper by Dr. Jackson and Dr. McCrae that appeared a year or two ago in the *Amer. Jour. of Med. Sciences* on the "Clinical Symptoms of Foreign Bodies in the Bronchi," which it behooves every one of us to read. A reprint of that paper may be obtained from the authors. In view of what Dr. Jackson says about peanut kernels, the paper should prove of interest. They tell us many other important things in that paper, and emphasize the value of the knowledge of the symptoms and physical signs, which lead us to suspect the presence of a foreign body in the chest in time to send the patients to the x-ray man and the bronchoscopist.

Dr. Henry B. Orton, Newark, closing: I thank you very much for this flattering discussion. Those men who are interested should read Dr. Jackson's article on "Non-opaque foreign bodies in the lung," in which Dr. Jackson gives you all the data in his usual, specific and concise manner. As to physical signs they vary. The more constant are, limited expansion; decreased vocal fremitus; percussion note impaired; and diminished intensity of breath sounds distal to the foreign body. You get valuable aid from the roentgenray as obstructive emphysema of invaded side; the heart and mediastinal wall moves over toward the uninvaded side; the invaded lung becomes less dense, from the trapping of air, and the diaphragm depressed on the invaded side.

THE REASONS FOR THE NEW HIGHER VOLTAGE SHORTER WAVE LENGTH ROENT- GENOTHERAPY.*

By **J. Thompson Stevens, M. D.**
Montclair, N. J.

Because of the many frequent questions that are constantly coming to me from physicians and surgeons regarding the new method of treatment by means of the roentgen rays, in the following paper, I shall try to answer clearly all of the questions that have been asked to date, as well as some that have not yet occurred to members of the medical profession.

Within the past three and a half years the medical profession has become deeply interested in the new roentgen technique, as applied to the treatment of neoplastic diseases, especially in cancer, sarcoma and benign tumors. Reports from Central Europe, Germany especially, of the astounding results obtained by the new methods of treatment are the direct cause of this increased interest in radiotherapy. The new method does not consist of newly-discovered

*Read before the Chiron Club, Montclair, N. J.

x-rays, but is a further development along well-known lines, as proven by the years of experience in the past. By increasing the voltage pressure upon an x-ray tube of greater dimensions and higher vacuum, rays are available of wave lengths approximating the gamma rays of radium. Therefore, the new treatment consists in the use of x-rays produced by extremely high voltages, which produces unlimited quantities of rays with penetrating power approximating the penetration of the gamma rays of radium. Physicists have had no trouble in producing machines up to 350,000 volts' capacity and even higher, but, until lately, no American tube would stand such voltages over long periods of time. Dr. Coolidge has, however, produced a tube which will operate successfully at voltages up to 220,000 for unlimited periods of time.

Modern practice demands that we acquaint ourselves with the essential factors of this new method of treating neoplastic diseases, that we may decide whether or not we wish to refer our cases to specialists for radiation therapy. What is the difference between the "old" and the "new" roentgentherapy? Is the "new" method more dangerous than the "old?" Are the results of the treatment better under the "new" technique?

In the past roentgen machines having a capacity of from 90,000 to 126,000 volts have been in universal use for therapeutic purposes, that is machines giving voltages equivalent of from a nine to a ten-inch spark-gap. The new apparatus will produce voltages up to 350,000 volts, that is voltages equivalent to a twenty-six-inch spark-gap, or more than twice that in common use. For the present, however, we cannot use voltages above 220,000, because of the limitations of the best roentgenotherapeutic x-ray tube that has appeared to date. These extreme voltages produce rays whose wave length closely approaches the wave length of the gamma rays of radium and, therefore, from a given dose of radiation as registered upon the skin, there will be a higher intensity in the depths following the new methods of treatment than is possible under the universal technique. A comparison of the effects of the new, harder type of x-rays and the gamma rays of radium upon the living tissue at once shows that more

penetrating x-rays have been produced and that we may look upon the new higher voltage apparatus as producing rays having practically the same physical characteristics as the gamma rays of radium. This discussion naturally raises another question. Why go to all this trouble in the production of higher voltage roentgen rays? Why not use radium? With radium we are so limited in our quantities of gamma radiations that we can only destroy cancer within three centimeters of our applicator, that is, with radium alone it is a physical impossibility to cure cancer, except skin cancer. It must be remembered that it takes approximately ninety-two grams of radium to equal the quantity of radiation coming from an x-ray tube working under the old technique. No one yet knows how much will be required to equal the total quantity of useful radiation coming from the x-ray tube working under the "new" factors. It is an economic impossibility to get even ninety-two grams of radium in any one institution in the world, seven grams is all that can be found in any one place at the present time. Therefore, I feel sure that you will agree with me when I say that if we are going to cure cancer by radiotherapy we must get our bulk of radiations to the disease by means of a roentgen ray apparatus. In this discussion I do not wish to go on record as being opposed to radium therapy. Radium has practically unlimited value when used with a thorough understanding of the physics of radiation therapy. Personally, I am constantly using radium, but I do not treat deep-seated cancer with radium alone. Here, radium is used within the diseased area itself, when the patient's measurements are such that it is impossible to deliver a knockout dose with the roentgen rays, that is, I am using radium to bring up my local intensities of radiation in patients of great dimensions.

Filtration of the rays has undergone equally great and equally important changes. Rays of many wave lengths are emitted by an x-ray tube. All but the shortest lengths are worthless for the treatment of deep-seated disease. By means of filtration we are able to absorb all of the longer wave-length radiations. With older technique aluminum of from three to six millimeters' thickness was used, while copper or zinc

in from one-half to one and one-half millimeters' thickness are used with the new technique. One millimeter of copper is about equal to twenty-three millimeters of aluminum. Filtration must be of such material and of such thickness as will give a homogenous radiation, which is determined for each apparatus by physical and biologic tests.

Under the older methods of treatment we all thought it necessary to get our x-ray tube as close to the skin as possible. Physical measurements of the intensities obtained in the depths, say ten centimeters below the surface, show that to obtain the best intensities in the depths we must get the tube as far away from the skin as time will permit. Time of treatment is increased directly, as the square of the distance increases. In actual treatment a focal distance is taken which will give us from 170 to 200 electrostatic units at the seat of the disease, employing the total number of ports of entry available. The necessary number of ports of entry are determined by the actual measurements of the case in hand and by physical measurements of the intensities obtained in the depths by means of an iontoquantimeter. With my deep therapy apparatus focal distances used are from fifty to ninety centimeters, according to the measurements in a given case, as just explained.

Ports of entry, that is areas for the application of the roentgen treatment have been remarkably increased in size with remarkable influence of the depth dose as a result. Formerly we all thought that it was absolutely necessary to use many, often very small ports of entry, which is a rational procedure in the light of our new knowledge of the part played by secondary radiations in bringing up our depth intensities of radiations. The most important of the secondary rays are called scattered radiations. The scattered rays are of the same wave length and have the same physical properties as the primary rays coming from the tube. It is a proven fact that the larger the port of entry, the greater the effect of the scattered radiation becomes.

Homogeneous roentgen radiation allows us to saturate each centimeter of tissue with a radiation of nearly equal intensity from the surface to the disease. With such a radiation the danger of severely damaging the skin is practically

eliminated. The conditions just mentioned are practically the opposite of the conditions obtaining in radium therapy. No matter how, when, or by whom radium is applied, it is a physical impossibility to secure anything like a homogeneous radiation. Radium needles and emanation seeds were conceived to overcome our inability to get a homogeneous radiation with radium, but to date has absolutely failed. To produce complete destruction beyond three centimeters with radium in either large or small amounts it is necessary to produce irreparable damage to nearby healthy, normal tissues, which is, of course, not a wise procedure. For instance, for a malignant growth of the uterus or the sigmoid, if we are to stand any chance of getting the patient permanently well we must get to every tissue within the entire pelvis, whose external boundaries are the bony walls of the pelvis, a homogeneous radiation of an intensity corresponding to not less than 170 electrostatic units. If we place radium packs on the skin, in view of the measurements of the smallest pelvis in existence, it at once becomes apparent that we can never get anything but a stimulating dose of rays to the center of the pelvis, that is to the seat of the disease. By placing the radium within the uterus the periphery of the pelvis will get a stimulating dose of rays, the lymphatics draining the area will not be sealed, due to inefficient radiation, and we may expect early, perhaps, distant metastasis, and failure from such treatment. The proper procedure here is to ray from the outside, with a homogeneous roentgen radiation, under proper methods of focal distance, proper size and number of ports of entry, as determined by actual measurement of the patient, and actual measurement of the intensity of radiation with an iontoquantimeter, and then to make up any deficiency in radiation intensities by the use of radium from within the uterus or sigmoid.

We cannot put through any one skin area more than one erythema dose of rays. An erythema dose is such a quantity of rays as will produce upon the skin, in from ten to twenty-one days, a slight reddening followed by deep tanning, then disappearance. This reaction is called 100 per cent. If an ionization chamber connected to an electroscope is exposed to a like quantity of radiation,

by a simple calculation, we learn that 170 electrostatic units have been delivered to that skin area. Seitz and Wintz, by unlimited investigations, found that one-third the above dose produced an ovary castration, three-fourths of the dose completely knocked out certain forms of sarcoma, and that 110 per cent. was the carcinoma dose. These men do not propose to have us believe that all we have to do is to administer the above doses and that all cases will get well promptly. So far as I am able to determine there is no physician who can cure every case of any disease that comes to his hand. The above figures are a basis for future investigations, and is one of the most valuable, if not the most valuable, contributions to modern medicine. The future will probably show that different types of cells in various growths require slightly different intensities than those given above to produce permanent satisfactory results.

As to the dangers accompanying this new method of roentgenization, it can be said that the higher the voltage, that is, the shorter the wave lengths used, and the more intense the treatment, the less the danger of damage to the skin. The above statement is the result of my own observations here in my own clinic, as well as in the clinics of others, who are using the "super" roentgen rays. This conclusion is what one would naturally expect from the physical investigations already referred to. In fact, there is less danger of damaging the skin than there is in giving an insufficient dosage. An insufficient dose in the end makes a bad case, worse. Carcinoma cells thrive on doses less than 60 per cent. of an erythema dose, which is borne out by the rapid extension of the disease in cases that are known to have had inefficient treatment. We must knock out the disease completely at the first treatments if we are to meet with any encouraging results, is a proven fact in any number of radiotherapeutic clinics. The only reactions in my hands that have ever caused any anxiety have been those observed in cases of carcinoma of the breast, in which the underlying tissues, the lungs, have received a very intensive crossfire. This has invariably cleared up in the course of a few months following the treatments, with one exception. One other patient who developed the same condition has

never reported to me since the treatments were completed, and must therefore be eliminated from the conclusions.

Intensive treatment of any part of the neck has very occasionally been followed by temporary aphonia. Some of the less severe reactions are: Dryness of the mouth and throat, oedema of the uvula, etc., all of which usually clear up in the course of a few days, but have occasionally lasted over a period of from one to four weeks, following treatment. Diarrhoea, bladder and rectal irritation are commonly complained of following intensive treatment of the pelvic organs. All of these complaints are temporary. They show clearly that the dose has actually been delivered to deep-seated organs. When they do not develop, following a treatment, the rule is, here in this clinic, to carefully check over the treatment. If it is found that the dose has not actually been given as expected, it is immediately made up by re-raying, that is, we expect these symptoms, after a properly given deep treatment.

In the days of the "old technique," when, in order to get our depth dose, it was necessary to repeat our treatments, month after month, it was sometimes found that there was a marked reduction of all of the constituents of the blood, that is, the red and white blood cells and the hemoglobin. Since the advent of the "new technique" we have been warned by the most conservative that a patient could never survive, because the blood would be destroyed beyond repair. However, in skillful hands, the massive dose method, with high penetration, is found to produce exactly the opposite condition. The average blood picture shows a reduction of only 5 per cent., the normal being regained in from a few hours to a few days. Patients do not have to be transfused after the treatments in order to save life. Transfusion has only been resorted to under the same conditions as it would be done were we to perform a surgical operation, that is, a patient having nearly bled to death from carcinoma of the uterus, for instance, would have to be transfused before any radiation could be given safely.

Whether this new method of treatment is going to be productive of more lasting results than the older method has, time alone can show. This paper is

not attempted to take up this question at this time, but is written now simply to lay before the medical profession the facts as nearly up to date as possible. However, in Germany, where the method has been under trial for several years, surgeons are gradually giving up the knife in certain forms of malignancy at least, because of the better final results obtained by radiation therapy properly done. Here in this country the immediate results that are being obtained in many cases are so encouraging and so much better than those obtained by the older methods, that it is reasonable to expect many more permanent cures than could possibly be obtained in the past. There is no question as to the value of the old method. Many, including the writer, have gotten some practically hopeless cases permanently well with it, while unheard of palliation has been accomplished in hundreds of cases. However, with the new method, in a series of unselected cases, more cases are cured than in the past and more lasting and greater palliation is obtained in others. In the strictly operable cases nearly 100 per cent. can be cured by a combination between a skillful surgeon and radiotherapist. From 80 to 90 per cent. of the strictly borderline cases can be gotten well. In the inoperable and hopeless cases the results are, of course, not nearly so good. Soon, I hope to be able to give statistics and technique of the results obtained in carcinoma treated by radiation therapy and skillful surgery, as practiced by some of the leading eastern surgeons with whom I have the good fortune to be more or less closely associated. Many of my surgical friends are demanding active postoperative radiation, others insist upon both pre and postoperative treatment. To date our statistics show that the best results are obtained, particularly in the borderline cases, that is, those that are just beginning to show superficial metastasis, in the cases that have preoperative treatment. This observation is in harmony with experimental work, that properly radiated cancer cells will not grow when transplanted.

Conclusions.

1. The "new" higher voltage, shorter wave length roentgen rays are a distinct step forward. They permit a homogeneous radiation of any depth within the body to be given, without the dangers of

the older methods of damage to nearby normal, healthy organs.

2. Radium should not be used alone in the treatment of any form of malignancy that has extended beyond the skin or that lies under the skin. The best use for radium is from within a malignant process, to bring up the local intensities to 170 electrostatic units.

3. Strictly operable cases should be treated surgically, plus pre and post-operative radiation.

4. Some definitely inoperable cases can be gotten well with radiation therapy skillfully carried out.

5. The hopeless cases should be treated by the older method of fractional dosage simply for palliation. The new method, by causing rapid destruction of cancer cells, is very apt to produce a fatal toxemia, due to absorption of necrotic debris.

SUBACUTE BACTERIAL ENDOCARDITIS IN A BOY FIFTEEN YEARS OLD—REPORT OF A CASE*

By Frank C. Johnson, M. D.,

New Brunswick, N. J.

The case here reported is a very typical example of that form of endocarditis, which has been variously termed endocarditis lenta, chronic septic, chronic rheumatic or septic rheumatic endocarditis, but now most generally subacute bacterial endocarditis. Sir William Osler, in 1885, first drew prominent attention to the disease, and the studies of Emanuel Libman at the Mt. Sini Hospital, in New York, have in the past fifteen years defined the clinical picture of this disease, as the most clean-cut of any class of endocarditis.

The causative organism is usually easily recovered from the blood stream, and is almost always a non-hemolytic streptococcus, a strain of low virulence and one to which the blood of normal individuals, as well as that of patients with subacute bacterial endocarditis, is usually bactericidal. The symptom complex is due to the low grade, persistent intoxication, to the amount of actual cardiac damage and finally, invariably and most important, to embolic manifestations caused by masses of thrombotic material, which contain great numbers of living organisms. It is a noteworthy

*Read before the Middlesex County Medical Society, September 15, 1922.

fact, on which authorities agree, that none of the infracts in this disease suppurate.

The recent death of Lord Northcliff, in England, from this disease lends interest at present.

The patient was a boy of German descent, fifteen years old, living on a farm, three miles outside of New Brunswick, and attending school here until the day when first seen, less than six weeks before his death. There is no family history of rheumatic fever, or of any other disease important in the case. He had always been considered a delicate child, and had had attacks of rheumatic fever from the time he was three years old. At that time several joints were envolved, causing pain, swelling and redness. Other attacks occurred when he was four, five, seven and thirteen years of age. During the last attack a well-known physician of New Brunswick treated him, and says that he had a well-marked endocarditis then. Five years ago was the first time that his mother was told he had heart disease. His tonsils and adenoids were removed five years ago.

The history of his final illness is very indefinite. The outset was insidious, and the patient himself insisted on carrying on for months, when he probably had an active endocarditis and septicaemia. He was seen first June 3, 1922, and said that ever since February he had not felt well. He came home from school exhausted in the afternoon and invariably laid down. For several weeks in March he was unable to go to school, but during April and May he attended regularly, but showed progressive loss of flesh and strength and became very pale. The thing that brought him to a doctor was a sudden pain in the left upper quadrant of the abdomen, which developed the day before he came in. This pain was made worse by respiration and he was quite unable to lie on his back, but lay prone with comfort. It was not known definitely whether he had had fever or not, but his mother thinks he had been feverish in the afternoon, for a long time.

He walked into the office on June 3, a bright, intelligent boy, but decidedly anxious appearing. He was extremely pale and rather sallow, but not definitely of the Cafe-au-lait color. He was thin to the point of emaciation. His temper-

ature was 101 degrees and pulse 130, rising to 160 during the examination. Blood pressure, 85 systolic, 35 dystolic.

There were no petechiae on the skin or mucus membranes. His eyes were normal, pupils reacting actively and there were no haemorrhages in the eye grounds. All the mucus membranes were very pale. His teeth were in good condition and his tonsils had been thoroughly removed. The superficial lymph nodes were everywhere small. The lungs were resonant; breath and voice sounds of normal quality, and there were no rales.

The whole precordium was lifted forceably with each cardiac systole. The apex impulse was diffuse, but the maximal point was three inches to the left of the mid-line in the fifth space. The left border percussed further out than it normally should, but the right border was within the parasternal line. The measurements of the area of cardiac dullness were: To the right, 1 inch in second space; 1 inch in the third; $1\frac{1}{4}$ inches in fourth, and $1\frac{1}{4}$ inches in fifth; to the left, $1\frac{1}{4}$ inches in second space, $1\frac{3}{4}$ inches in third, 3 inches in fourth, $3\frac{1}{2}$ inches in fifth and $3\frac{1}{2}$ inches in sixth. At the apex the sounds were regular and loud. The first sound was preceded by a short, rough pre-systolic murmur and followed by a loud, rough murmur, filling the whole space between the first and second heart sounds. This could be heard over the entire precordium and over the entire left chest in fact. The pulmonic second sound was not notably accentuated. There was a short, low systolic murmur heard at the base, loudest at the aortic area.

He could not lay down flat on the examining table, on account of pain in the left upper quadrant. The abdomen was not distended, but was distinctly full looking in the left upper quadrant, and there was so much muscle spasm here that it was impossible to outline any mass, though the percussion note was dull to flat and a moderate amount of dull tenderness extended over the whole area of the left of the mid-line and above the iliac crest. The liver edge was not felt. The genitals were normal, knee jerks active and there were no subcutaneous nodules.

His blood count: Red blood cells, 2,500,000; white blood cells, 7,500; polymorphonuclear leucocytes, 68, and sma'l

lymphocytes, 2. Urine showed a faint trace of albumen, but no cellular elements.

The diagnosis was made of chronic cardia-valvular disease, with mitral regurgitation, as the prominent lesion; the temperature being explained, in my mind, at the time, as a recurrence of rheumatic fever; the pain on breathing by pleurisy of rheumatic origin and the tumor in the left upper quadrant possibly a congested spleen of cardiac insufficiency.

He was put to bed for treatment and observation. The treatment was entirely symptomatic, but the development of the case became at once interesting and distressing.

The temperature from the first ran a septic course up to $103\frac{1}{2}$ degrees in the afternoon and down to normal in the morning. Salicylates did not affect it, and digitalis did not slow his pulse. It was a week before a satisfactory examination of the abdomen could be made. Then it seemed that the mass in the left upper quadrant had the feel and outline of a huge spleen, extending almost to the mid-line and four inches below the costal margin. The liver could be felt 3 cm. below the costal margin. The sharp pain in the splenic area subsided. Continued search for petechial spots in eye grounds, skin and mucus membranes was rewarded by the finding of a single petechia in the left conjunctiva sac at the end of three weeks. This is the only one I saw and was sure of. He had repeated attacks of sharp pain from time to time, in the splenic region, once occurring while he was at Middlesex Hospital, causing cyanosis dyspnea and profuse sweating.

There was some doubt about the etiology of the pain and mass in the left upper quadrant and exploration was suggested and seemed indicated until the blood was taken for culture. This was on June 23, the day after the only petechial spot was found, and a growth of anhaemolytic streptococcus was obtained in both tubes of broth. His blood count then was: Red blood cells, 2,400,000; white blood cells, 12,200; polymorphonuclear leucocytes, 42, and small lymphocytes, 28. The diagnosis was at once clear, that of subacute bacterial endocarditis, with multiple splenic infarcts.

There were two subsequent blood cul-

tures, both showing the same organism in pure culture. His general condition grew progressively worse. With the temperature constantly running high, weakness, dyspnea and orthopnea increased and pallor became more and more marked. On some days there were rales at the bases of the lungs, but these never persisted. There was no sign of fluid in the lungs or pericardium, and there was no edema until the day before his death. One week before he died there developed an anaesthesia of the left leg, from below the knee down. With this there was a little tingling and a very unpleasant numbness. The part was more cool than normal, but the circulation was not cut off. He could move his toes and foot easily. In the course of several days this cleared up very noticeably. To account for it by a cerebral lesion is difficult, leaving one the improbable diagnosis of thrombosis of a small vessel supplying an area in the right cerebral cortex in the post-rolandic region.

The heart remained regular, except for slight digitalis effect and forceful until only two days before death. The pulmonary second sound was not accentuated until ten days before death.

On the 12, 13 and 14 of July he failed markedly. His temperature remained subnormal, his face became oedematous and the heart weak and finally irregular, and he died on July 15.

I was not present at death.

Autopsy was performed five hours post-mortem.

The body was that of a fifteen-year-old boy, markedly emaciated, the subcutaneous tissue was practically devoid of fat. There were no petechiae or ecchymotic areas present. The only edema was a slight amount of the face.

The abdominal cavity contained very slightly more than a normal amount of thin, straw-colored fluid. The right pleural cavity contained about a liter of thin, clear, yellow fluid. The left pleural cavity contained none. Both lungs were perfectly free in the pleural cavities. They were not removed, but by palpation seemed air containing and uniformly crepitant.

The pericardium contained 100 cc. of clear, yellow fluid. The perietal pericardium was smooth and glistening. There were no adhesions between it and the visceral pericardium. At the very apex

of the heart, on the anterior surface of the left ventricle, there were two small tabs of fibrin, and on the posterior surface of the left auricle there was a patch of roughening that corresponds with the underlying endocardial lesion, as though the inflammation had involved all coats of the auricular pericardium at this point. Elsewhere the visceral pericardium was perfectly smooth and glistening. There were no petechial haemorrhages. The heart weighed 400 grams (200 normal, for his age). On section the myocardium of the left ventricle showed a few small fibrous patches near the apex. The wall measured $1\frac{1}{2}$ cm. in thickness. The left side of the heart showed the important lesions in the case, consisting of old and recent vegetations about the mitral valve and the structures adjacent to it. The valve measured 9 cm., which is about normal. The anterior leaf was very much thickened by old rheumatic infection, but the posterior leaf was so completely involved in the mass of more recent lesions that it was impossible to say that it was previously damaged. The starting point of the infection being assumed to be at or near the line of closure of the valve leaflets, the bacteria had very evidently progressed downward on the chordae tendinae, covering them with organized, irregular, rough, nobby thrombotic material, completely severing the chordae in many instances and coating over their ends. This left the loose ends of the chordae flapping back and forth in the blood current, with material on them that could be very easily snapped off and set free in the blood stream. On the auricular surface of the posterior leaf of the valve the growth of bacteria was extensive, forming a great, rough mat of thrombus that spread over the valve itself and upward over an area on the surface of the auricular endocardium $3\frac{1}{2} \times 4$ cm. This auricular spread of the lesion occurs, according to Homer Swift, in one-half of the cases of infection, with the streptococcus viridans. There was no actual ulceration of the valve itself and there is no involvement of any other valve in the heart. The aortic cusps are perfectly normal, the orifice measuring 6 cm. The right ventricular wall measured from .2-7 cm. in thickness, the tricuspid valve orifice, 9 cm.; the pulmonic, 6 cm., and their structure seemed quite normal. The fine chordae

tendinae of the tricuspid valve are in striking contrast to the beaded, thickened ones of the mitral.

The liver was distinctly enlarged, extending 8 cm. below the costal margin in the mid-clavicular line. It was not removed owing to the unfavorable circumstances under which the autopsy was done.

The spleen weighed 510 gm. (195 normal, for a man). It measured $15 \times 10\frac{1}{2} \times 5$ cm.—fully three times the normal size. It was loosely adherent. Near the upper pole to the parietal peritoneum, as gentle traction was made on it, the hilus structure gave way and the spleen was removed. The ease with which the vessels were torn is explained by examination of the remains of one artery, the branch to the upper half of the organ. It was completely thrombosed, and it may be that some of the other vessels had been recently occluded, too. The capsule was very tense, and the surface of the organ was shaggy, with organized fibrin over the large, yellowish areas, and smooth and glistening over the other apparently normal areas.

On section the distribution of one large infarct and several typical small ones was strikingly evident. These were of a dirty, yellow color and rather dry on section. The largest one was due to the occlusion of the vessel that was demonstrated, and involved the whole upper half of the organ, measuring $6 \times 10 \times 5$ cm. It was just beginning to break down slightly in the uppermost part. The splenic substance, between the infarctions, was of a dull, pasty appearance and pinkish-grey in color. The cut surface stood up above the capsule, everting the edges, and there was little blood on the cut surface. This is the typical picture of the so-called acute splenic tumor, which results particularly from such a septicaemia as this, and from other long-continued streptococcus, staphylococcus and pneumococcus infections. It differs from the swollen typhoid spleen in that the enlargement is due to a great accumulation of leucocytes in the splenic pulp, compressing the venules and causing the greyish appearance, where, as in the red typhoid spleen, there are great numbers of red blood cells scattered through the pulp, and the vessels are dilated.

The left kidney was larger than normal, weighing 140 gm. (130 normal, for an adult male), and measured $10 \times 4\frac{1}{2} \times$

4cm. The capsule stripped easily, leaving a smooth surface, but mottled with ochre, yellow patches, 1-2 cm. in diameter, and numerous fine haemorrhages. On section there were typical triangular areas of infraction scattered through the cortex, and numerous haemorrhagic areas in the pyramids and medullary portion of the organ, evidence of an acute nephritis.

The Anatomical Diagnosis, therefore, was:

1. Chronic cardiac valvular disease, with engrafted upon it an anhemolytic streptococcus endocarditis, with vegetations on the mitral valve, involving the chordae tendinae, causing their rupture and spreading over the endocardium of the right auricle.

2. Septicaemia.

3. Fibrinous pericarditis - hydropericardium.

4. Right hydro-thorax.

5. Thrombosis of splenic artery, with splenic infarcts.

6. Thrombosis of renal vessels, with renal infarcts.

7. Acute splenic tumor, due to septicaemia.

8. Localized fibrinous peritonitis, i. e., perisplenitis.

9. Chronic passive congestion of the liver.

10. Undemonstrated cerebral thrombosis.

Summary.—The outstanding features of this case are impressive; the insidiousness of the disease, which was probably present for a period of several months before the boy was taken to a doctor, the violence of the symptoms that finally brought the patient under observation, and the short course from that time to the termination. The patient was known to have had a rheumatic endocarditis for several years, and but for the fact that one does not expect to find subacute bacterial endocarditis in children frequently, the diagnosis should have been made sooner than it was, after he was first seen. The blood culture was not taken until the first and only petechial spot was seen, in spite of a constant septic temperature and the signs of splenic infarcts. It was even contemplated to operate on the mass in the left upper quadrant, with the hope of finding pus there, but after the blood cultures had shown the non-hemolytic streptococcus repeatedly, the explana-

tion of everything was simple, and the autopsy findings could be easily predicted. The difficulty of treating an infection situated as this one is, and having for its source solid masses of bacteria and fibrin, which, by their very physical state, is a protection against any serologic action, is readily appreciated. However, we were making an autogenous vaccine with which to rapidly immunize a donor from whom we expected to take enough blood to obtain 200 cc. of serum for a single large dose, giving a high titre of agglutinins. This procedure has lately been used in Boston, with success in four out of a series of five cases.

County Medical Societies' Reports.

ATLANTIC COUNTY.

Royal E. Durham, M. D., Reporter.

The regular monthly meeting of the Atlantic County Medical Society was held at the Hotel Chalfonte, Atlantic City, on Friday, December 8th, 1922.

Dr. Arthur Davidson of Philadelphia, spoke on "Back Pain Due to Orthopedic Conditions," and Dr. John H. Gunter spoke on "Referred Pain from the Nasal and Oral Cavities."

Dr. Davidson first took up the anatomy of the pelvis. He said there were three kinds of pelves, i. e., the female type, male type and transitional form. The female type is a high set pelvis with a narrow sacro-iliac joint and is the weakest type. The male is a low pelvis, with a wide sacro-iliac joint and is the strongest type. The transitional type is between the forward curve of the lumbar vertebrae, thus throwing the entire body weight upon the sacrum.

The main orthopedic conditions causing back pain are acute sprains and displacements of the sacro-iliac and lumbo-sacral joints. The cause is usually always trauma and may be due to falling, twisting or direct blows in that region. The symptoms of acute sprains are pain in back, rigidity of muscles, tenderness upon pressure over the joints; Kernig's sign may be present and the patient may bend toward the injured side with ease, but cannot bend to opposite side because of pain. The pain is always either uni-lateral or bi-lateral according to extent of injury and never directly in mid-line of back. In displacements of the joints the above symptoms are apt to be more pronounced and in addition, we hear a distinct click of the bones as they slip into place upon proper manipulation.

Another condition spoken of was sacralization or enlargement of transverse process of lost lumbar vertebra with impingement of the process upon the iliac crest. The symptoms here are the same as above with exception that pain is greatly accentuated when patient bends toward the good side and there is apt to be a more severe associated sciatic neuritis. As to sciatic pain we must differentiate be-

tween an irritation of the sciatic nerve and an actual sciatic neuritis or rheumatism, as it is called. In the former the trouble is higher up as, for instance, a sacro-iliac displacement and we have sciatic pain but no tenderness upon pressure over the nerve. In sciatic rheumatism we always get tenderness upon pressure over the nerve as well as pain.

The treatment is rest. It is advisable to keep patient out of bed but the back and pelvis should be immobilized. At night patient should sleep on a hard bed with a pillow or pad in small of back. At this point a plea was made to protect all patients at operation by placing pad under small of back while on a hard operating table. This will prevent much of the post-operative back-ache. Immobilization is established by means of adhesive straps, plaster casts and properly made supports. Very bad cases do well in bed with extension on extremities. In displacements we must try manipulation with patient on back and forcibly flexing thigh on abdomen or patient on abdomen and forcibly extending thigh. In most cases we hear a click as the bones slip into place and we then follow out the treatment with rest and immobilization. During convalescence massage, electro-therapy and hydro-therapy are indicated.

Dr. Gunter, in his paper, made a plea for a more careful study of the nasal and oral cavities as the seats or causes of referred pain of the head and neck. He gave an interesting report of cases in which pain was caused by deflected nasal septums or encroachment of a turbinate upon the septum. In many of these cases all teeth were sacrificed before the cause was found in the nasal cavity. Other cases, in which operations upon the nose had not relieved referred pain, were completely relieved after an offending tooth had been found and removed. He said there was too much pulling of teeth and strongly urged upon us the importance of always having xray study before any tooth whatsoever is removed. Referred pain is often remote from the seat of the trouble and involves the wide distribution of the trigeminal nerve. Hence importance of study of both oral and nasal cavities before any definite conclusion is reached as to its cause.

BERGEN COUNTY.

Frederick S. Hallett, M. D., Reporter.

The regular monthly meeting of the Bergen County Medical Society was held at the Union League Club, Hackensack, Dec. 12th, 8.30 p. m. Vice-President Dr. G. L. Edwards accepted the chair, with 26 members in attendance. A communication was read from Dr. C. A. De Mund, of Ridgewood, offering his resignation, because of illness and retirement from practice. On motion, Dr. De Mund was elected an honorary member.

The following applicants were elected to membership: Drs. Flora Adams, Hackensack; C. H. Dezer, Englewood; James W. Fox, Hillsdale; H. E. Gillett, Ramsey.

Scientific Program.—Dr. Harvey B. Mathews of Brooklyn read a very interesting and instructive paper on "The Use of Radium for the Treatment of Non-Malignant Uterine Bleeding." Questions were asked by members and answered by Dr. Mathews.

CAMDEN COUNTY.

At the annual meeting of the society, October 10, Dr. Daniel Strock, who for many years had efficiently served as secretary of the society, declined re-election. The society gave expression to its appreciation of his long service and regret at its closing, and it was resolved to give him a complimentary dinner.

HUDSON COUNTY.

William Freile, M. D., F. A. C. S., Reporter.

The Hudson County Medical Society met at the City Hospital on December 5, 1922.

In regard to the investigation of clinical laboratories, on motion of Dr. George E. McLaughlin, a committee was appointed, consisting of several members, who had no connection with laboratories, to investigate the conditions. The chair appointed Drs. Leopold, of North Hudson; Cassidy, of Jersey City; Brooks, of Bayonne; Von Deusten, of Hoboken, and Jaffin, of Jersey City.

The chair also appointed, as the membership committee, Drs. Kuhlman, of North Hudson; Longergan, of Hoboken; Maver, of Jersey City, and Bollinger of Jersey City.

Dr. William J. Sweeney, of North Hudson, offered a resolution, which was carried, condemning the restrictions prescribed in prescribing alcoholics in the practice of medicine.

The legislative committee, from last year, was reappointed to continue the work.

The auditing committee, consisting of Drs. Cosgrove, Neury and Swiney, was continued.

Dr. Quigley, of North Hudson, reported on the work of the legislative committee that they were taking cognizance of the legality of practitioners of medicine of midwives and the status of chiropractors, osteopaths and naturopaths.

The paper of the evening was read by B. S. Pollak, M. D., F. A. C. P., medical director, Hudson County Tuberculosis Hospital and Sanatorium; Phthisiologist, Jersey City Hospital and Consulting Phthisiologist of St. Mary's Hospital, Hoboken, entitled "The Effect of Pregnancy on Tuberculosis."

The paper evoked widespread discussion, among which Dr. A. E. Jaffin, F. A. C. P., associate physician, City Hospital, and attending physician, Jersey City Tuberculosis Clinic, spoke on "The Evaluation of Symptoms and Signs in the Diagnosis of Pulmonary Tuberculosis."

Following the above, Dr. M. I. Marshak, of Bayonne, spoke on the "Climate in the Treatment of Tuberculosis."

MERCER COUNTY

A. Dunbar Hutchinson, M. D., Secretary.

The annual meeting of the Mercer County Medical Society was held on December 13, the president, Dr. Olmstead, presiding. In order that members coming in late might have the benefit of the reading of the essay, routine business, with the election of officers, was transacted first.

The treasurer's report for the year was read, and the auditing committee, Drs. Scammell and Kuhl, reported that the books showed a substantial balance on hand.

Dr. Donald B. Sinclair, of Princeton, and Dr. Leslie A. Yeager, of Trenton, were elected to membership.

Dr. Wareham, of Bucks County, Pa., was asked to sit with the society and enjoy the fellowship of the meeting.

The election of officers then took place, as follows: President, Dr. Henry A. Cotton, State Hospital; vice-president, Dr. Henry J. Collins; secretary-reporter, Dr. A. Dunbar Hutchinson; treasurer, Dr. Harry R. North; censor, Dr. George R. Moore, for three years.

Annual delegates to the State Society, Drs. William D. Olmstead, Martin W. Reddan, Harry R. North and Samuel Sica; alternate delegates, Drs. Paul E. Kuhl, Edgar L. West, Daniel L. Haggerty and Horace D. Bellis.

Dr. James J. McGuire was elected a member of the nominating committee.

The retiring president then presented Dr. Cotton, the newly-elected president, who, in his usual grace, expressed his pleasure in the honor conferred upon him, and spoke most enthusiastically of the prospect for a very interesting and instructive year.

The president appointed the following committees: Program, Drs. E. S. Hawke, A. W. Atkinson, Samuel Sica; membership, Drs. F. G. Scammell, R. D. Scarlett, William A. Clark.

The resignations of Drs. R. Grant Barry, of the State Hospital, and L. L. Freidmann, of Trenton, were read and accepted.

A cordial invitation from Dr. C. L. Andrews was read and accepted, inviting the members to attend a meeting of the Atlantic County Society, to be held January 12, 1923. Several members were appointed to represent this society.

The speaker of the evening, Dr. A. E. Shaffer, was then introduced. The subject of the paper was "The Diagnostic and Prognostic Value of Blood Chemistry."

This proved to be a most interesting topic, and the wide discussion by the members displayed the thoroughness with which the author treated the many phases of this new line of laboratory research. As Dr. Shaffer is at present reconstructing his paper, he will soon present it for publication in your valuable Journal.

MIDDLESEX COUNTY

James L. Fagan, Secretary.

The annual meeting of the Middlesex County Medical Society was held, December 20, at 4:30 p. m., at the Hotel Klein, New Brunswick. Dr. B. M. Howley, the president, presided at the meeting, which was unusually well attended. Officers for the year 1923 were elected, as follows: President, Dr. C. W. Naulty, Perth Amboy; vice-president, Dr. A. L. Smith, New Brunswick; secretary, Dr. J. F. Weber, South Amboy; treasurer, Dr. D. C. English, New Brunswick; delegates to State Society, Drs. Charles F. Merrill, Charles I. Silk, A. L. Ellis; alternates, Drs. A. Gruessner, M. F. Urbanski, William F. McCormick.

Drs. Herman A. Schaffer and Frank C. Henry, of Perth Amboy, were elected members.

Dr. James Hunter, Jr., president of the State Society, in a short address, urged all members to take advantage of the group liability insurance plan, which was being

offered physicians by insurance companies at reduced rates, provided a sufficient number subscribed.

Dr. D. C. English spoke of the great importance of having annual dues of members in the hands of State Society Treasurer Marsh's hands before January 5.

After the business meeting, Dr. John F. Hagerty, Newark, read a very enjoyable and instructive paper entitled "Some Interesting Surgical Cases." After considerable discussion of Dr. Hagerty's paper, the meeting adjourned for the annual dinner.

MONMOUTH COUNTY.

David M. P. Maghee, M. D., Reporter.

The Monmouth County Medical Society held its annual meeting at the American Hotel Freehold, President Warner, presiding.

The following were elected for the ensuing year: President, Dr. G. Van Voris Warner, Red Bank; vice-president, Dr. Henry W. Ingling, Freehold; secretary, Dr. John C. Clayton, Freehold; treasurer, Dr. William A. Robinson, Ocean Grove; reporter, Dr. David M. P. Maghee, Long Branch; annual delegates to the State Society, Drs. J. E. D. Silcox, Keyport; J. P. Hochbruckner, Farmingdale; permanent delegates, Drs. William K. Campbell, Long Branch; Harry B. Slocum, Long Branch.

The president, secretary and treasurer were re-elected. Dr. Harry E. Shaw is our other permanent delegate, who was elected several years ago.

This meeting was probably one of the best attended that this society has ever had, and the interest shown was by far the greatest. The year just past has been one fruitful in many ways, not the least of which is the awakened interest. The president worked hard and faithfully, with the result that the society is probably in better condition and more active than ever before in its history. The end is not yet, however, for the coming year promises well to exceed its predecessor.

There is no joy which is not mixed with a little sadness, and we have had our share of the latter. During the past year God Almighty, in His infinite wisdom, has seen fit to call to their eternal reward two of our number, Dr. Charles Jamieson, of Asbury Park, and Dr. Edwin Field, of Red Bank. The society feels keenly the loss of both of these members, and their memory will be held in reverence by their brothers, who have been left behind. We trust that their example will be an incentive to added efforts on the part of all of us for better work.

We venture to say that a large proportion of the readers of the Journal do not know that the Monmouth County Medical Society was founded and held its first meeting in Freehold in 1816, completing this year just past its 106th year. The original minute book of the society is still in our possession and in good condition and, fearing that it might suffer loss or accident, we have entrusted it to the keeping of the Monmouth County Historical Association, although we are not willing to give up title to it, as we consider it as a priceless possession, and one that sheds light on the history of medicine in New Jersey and in our county in particular.

We anticipate a year in 1923 in the practice of medicine in this county such as has never been equalled and one that will cause our society to appear well toward the front in accomplishment.

MORRIS COUNTY

Marcus A. Curry, M. D., Reporter.

The December meeting of the Morris County Medical Society was held on the evening of the 12th in the Lunch Club Room, at "Day's", in Morristown. President Lathrope presided over a fair attendance of members and there also was present, as a guest, Dr. Harry L. Alexander, attending physician at Bellevue and chief of the Asthma Clinic at Cornell Medical College. The order of business was suspended, so as to make way for the reading of a paper on the subject of "Asthma," by Dr. Albert Vander Veer, of the Columbia University, New York.

In introducing Dr. Vander Veer, the president stated that the doctor is closely associated with the man who has made a good deal of the history of asthma of late years, Dr. Robert Cook. The president also reviewed a little of the line of work with which he happened to be familiar, as he had long known the doctor, and was acquainted with a good deal of his work; that he and Dr. Cook were in the hospital together, and that whenever Dr. Cook was called upon to go out on a horse-drawn ambulance he had a terrible attack of asthma, so that the superintendent of the hospital, who happened to be a sufferer from asthma and having a fellow feeling for Dr. Cook, gave orders that when Dr. Cook went on the ambulance he should have the electrically-driven vehicle; that out of that experience Dr. Cook began this work and the interest he has taken in it.

Dr. Vander Veer read his ably prepared paper on asthma in a manner that held a peculiar grasp upon the attention of the members. He stated at the outset that it was his endeavor to bring out in his paper some practical points in the diagnosis and treatment, which might be of value to the general practitioner, who sees, perhaps, a dozen or so of cases during the year, and is anxious to give them the benefit of the newer discoveries, but at the same time is unable to spend his entire time following the subject, as a specialty. (The paper has been submitted to the Journal for publication). The paper brought forth an unusual amount of discussion. Among those taking part in the discussion were Drs. Flagge, Krause, Alexander, Foster, Larson, Glazebrook, Horn and Curry. All questions were cheerfully and lucidly answered by Dr. Vander Veer, who was given a rising vote of thanks for his exceedingly able paper.

The Venerable James Douglas, treasurer-emeritus, supported by the gold-headed cane, a token of the esteem of the members upon the occasion of his retirement from office, was surrounded with felicitations upon his presence at the meeting, and he was unanimously elected to honorary membership in the society.

There was a fire reading of several amendments to the bylaws, which are designed to facilitate the business part of the meetings,

so as to leave more time for strictly medical matters.

President Lathrope announced an outline of the program for the March and June meetings, which was laudably ambitious and should serve to quicken the interest of any seemingly indifferent members of the society.

An enjoyable luncheon was served. The March meeting will be held at Dover.

PASSAIC COUNTY.

Leon E. De Yoe, M. D., Secretary.

The November meeting of the Passaic County Medical Society was held at Odd Fellows Hall on Thursday evening, November 9 at 8:45 p. m. President Marsh, in the chair.

President Marsh announced the formation of the Passaic County Milk Commission, composed of the following men: Drs. J. N. Ryan, temporary chairman; C. J. Murn, temporary secretary; F. H. Todd, Sidney Levine and L. G. Shapiro.

The Board of Censors reported favorably on the applications of Drs. B. E. Wilkinson and A. E. Meneve, and these men were unanimously elected to membership.

The president then spoke of the question of suits against physicians for malpractice, and deplored the fact that if the insurance company decides to settle, the physician is practically obliged to consent. The president then introduced Dr. W. B. Johnson, of the special State committee on insurance, and Mr. Faulhaber, the agent for the United States Fidelity Company, of Maryland, who are handling this work for the State Society. These gentlemen explained in detail the advantages of the new insurance, and urged all members to avail themselves of the opportunity offered. The subject was further discussed by Drs. Maclay, McCóy, Keller and Hennion.

December Meeting.

The December meeting of the Passaic County Medical Society was called to order by President Marsh on December 14 at 9 p. m. Dr. H. N. Golding was appointed temporary secretary.

Dr. S. B. English, of Glen Gardner, spoke on the subject of "Tuberculosis." He enumerated the symptoms and signs which indicated early tuberculosis and emphasized the importance of the xray and the clinical laboratory as aids in diagnosis. He then related something of the history of the fight against this disease, and mentioned the importance of the education of the public in matters of general hygiene, the betterment of factory and home conditions, the advantages of open air schools. He then told of the work of the sanatoria and tubercular clinics, and announced the establishment of a State tubercular clinic at Pompton, N. J. Paper was discussed by Drs. Hagen and Murn.

Dr. William A. Dwyer then read a paper on "The Indications for Version." This paper was discussed by Drs. Cogan and Feigenoff.

We have been compelled to defer insertion of some reports, because of their late arrival, and also of the Cape May Society, because of its great length. The latter we deeply regret, for it was decidedly the largest and best meeting that society ever held.

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OF THE

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Each member of the State Society is entitled to receive a copy of the JOURNAL every month.

Any member failing to receive the paper will confer a favor by notifying the Publication Committee of the fact.

NOTE.—The transaction of business will be expedited, and prompt attention secured if,—

All papers, news items, reports for publication and any matters of medical or scientific interest, are sent direct to THE EDITOR, New Brunswick.

All communications relating to reprints, subscriptions, changes of address, extra copies of the JOURNAL books for review, advertisements, or any matter pertaining to the business management of the JOURNAL are sent direct to THE CHAIRMAN OF THE PUBLICATION COMMITTEE, Newark

An Old Thought for the New Year

Listen to the salutation of the dawn:

"Listen to this day

For it is the Life, the very life of Life.

In its brief course lie all the realities of
your existence:

The glories of action.

The bliss of growth.

The splendour of beauty;

For yesterday is but a dream,

And to-morrow is only a vision;

But to-day well lived makes every yesterday

A dream of happiness,

And every to-morrow a vision of hope "

—From the Sanskrit

DO NOT FORGET OR NEGLECT

As all county treasurers and secretaries know, our by-laws require that every member shall pay his annual dues on or before January 1st of each year if he wishes to keep in "good standing" and be so reported to the A. M. A. In the list which we wish to print in January to go out with the February number of the Journal, we shall print the names of all members who have paid their dues

for the year 1923 and are in **good standing**. This list is taken by the A. M. A. as their list of members in good standing and if a member is reported as not being in good standing he will know that he has not been reported by his county treasurer as having paid his dues for the year 1923. Therefore let every member pay his dues promptly on or before January 1st, 1923, and be reported as being in good standing for the coming year. County treasurers should turn these dues promptly over to the treasurer (Dr. E. J. Marsh, Paterson, N. J.) so that the secretary may know that these dues have been paid into the State Society funds. We trust that every member will heed this notice and thus save a great deal of annoyance to himself, as well as unnecessary labor for the secretary.

William J. Chandler, Secretary.

VOLUME XX—1923

We begin another volume of our Journal this month and the Editor believes it will be a better volume than any that has preceded it; that it will more fully set forth the excellent work the medical profession is doing in New Jersey, and will be more helpful generally to our members. The reasons for our belief are: 1. There will be more time given to its preparation by the Editor, as he expects soon to retire from the active practice of medicine; 2. Because of the inspiration that comes to us all by the consideration of the splendid lives and work of the noble men, whose deaths or century anniversaries occurred since our last Journal was issued, and is elsewhere referred to, has profoundly impressed us; 3. By the signs of largely increased activity of the officers and members of our county societies; 4. By the outlook for the largest and best annual meeting in June that our State Society has ever held; 5. By the large supply we already have of able and practical Original Articles awaiting publication. And yet we shall not be able to make the Journal what we wish it to be without the hearty co-operation of all our officers and members—it is **their Journal, not ours**. Let us all, therefore, unite to make it worthy the Society it represents, and to make ourselves more worthy of membership in that Society and in the great profession for whose advancement and increased efficiency in service that noble Society

stands. With this end in view we call special attention to another editorial entitled "Our Greatest Needs," which should receive careful thought, leading to prompt and continued action.

INSPIRATION FOR SERVICE

**"Lives of great men all remind us
We can make our lives sublime."**

It has been said there is at times a sublime significance in dates. There probably never was a time when that proved more true than during the closing days of the old year. It does not seem possible that it was a mere happening that fixed our minds on the characters and works of some departed great men, but that it was a Providence, full of meaning, to prepare us for entering the New Year more thoughtfully, more splendid opportunities and great responsibilities—and more determined to follow in the footsteps of the departed.

Two of these great men passed away the same day—December 11:

An Ideal Physician—M. Royal White-nack.

scious of the grandeur of true life—its

An Ideal Merchant—John Wanamaker.

Of the first-named we preferred that his pastor, Rev. Dr. Chapman, of Newark, should speak, and we asked him to give our Journal an outline of his beautiful tribute, paid at the funeral of Dr. Whitenack. It will be found on page — Of the latter, we give Mr. Wanamaker's own biography, sent by telegram in reply to a request for a sketch of his life: "Thinking, Trying, Toiling and Trusting in God is all of my biography."

Then on December 27 we celebrated the 100th anniversary of the birth of two other great men:

An Ideal Scientist—Louis Pasteur.

An Ideal Man of Letters—Matthew Arnold.

Of Louis Pasteur, one has said: "He was a gentle soul, deeply religious, wholly unselfish, fearless and tireless in the defense of truth." His belief was bounded by two words: God and Work. His last words were: "We must work." To him and Joseph Lister, who said he owed much to Pasteur's discoveries, we largely owe our profession's great work in preventive medicine.

Of Matthew Arnold it is said there was no one among men of letters of the nineteenth century more noted for intellectual power and authority, or of

more commanding influence. His poems are regarded as of exquisite quality, his elegies of supreme beauty, tenderness and depth of feeling. He was devoted to duty, was of unswerving integrity, courageous in opposition to evil and advocacy of the right.

Two other very able men passed away during the last of December—Dr. Edwin Field, of Red Bank, director for many years of the Monmouth Memorial Hospital, Long Branch; one of our ablest surgeons and a man greatly esteemed; and Dr. William S. Disbrow, of Newark, who for many years was a member of the Board of Health, serving several terms as its president, also one of the founders of the Academy of Medicine and a large contributor of books and scientific and art objects, which he spent years in collecting.

The deaths of these great men should make a profound impression on us all, as we enter the New Year, and the inspiration that comes from their devoted lives and splendid service **ought** to make make the New Year the most memorable one in the history of our profession. **We believe it will**, and in that faith we wish all our members a Happy and Prosperous New Year.

OUR GREATEST NEEDS

The two greatest needs of the medical profession are: 1. The insistence on the observance of the demand that none but thoroughly educated doctors shall enter its ranks and that the profession shall be more thoroughly organized for progressive and efficient service; 2. That the public shall be educated concerning the objects and aims of the profession, especially those that affect the welfare of the public in the care and protection of the lives and health of citizens and the condition of the community, as related to health.

We need to realize today, more than ever before, not only the greatness, but also the solemnity of our calling and the responsibilities connected therewith. Our laws, very properly, require years of preparation, at thousands of dollars' expense of those who propose to enter upon the practice of medicine, and afterwards life-long study is necessary to keep up with the constant advance in the science and art of medicine, and that study consists largely of reading thoughtfully medical literature and mingling

with our brother practitioners in medical society discussions. It is, therefore, an imperative necessity that our profession shall be far more thoroughly organized than it has been. We have been so busy looking after the public's welfare in the work of preventive medicine, the establishing of hospitals, sanatoriums, health departments, etc., that we have neglected the duty we owe the profession and ourselves as members of it, in making ourselves better prepared to meet its responsibilities, even in our personal work for the public's welfare; while the false cults and quacks have been deceiving the public and enriching themselves.

Specific Needs: 1. That every reputable physician in New Jersey be enrolled as a member of his county's medical society and that his name be enrolled in the official list to be published by the State Society in February. That enrollment is of far more value than most doctors realize, as it largely fixes one's standing in the practice of medicine in this State and in the United States. To be enrolled one's dues must be in the hands of Treasurer Marsh, of the State Society, before January 10.

2. That every member shall attend every meeting of his county society, if possible, and help to make it interesting and profitable. A good program should be provided for each meeting; practical papers and reports of cases should be presented and discussed. In next month's Journal we shall editorially comment on the member who says: "I don't read medical journals," and "I don't attend county society meetings." We are glad to report hopeful signs for the future. The Cape May, Middlesex and Monmouth societies each recently held the largest and best meeting ever held, with every indication of increased life and activity. This is due largely to the active and efficient service of the officers. In Monmouth, President Warner's activity during the past year so impressed the members that they insisted on his reelection for 1923, though contrary to custom and against his expressed wishes.

3. That every officer and every committee of a county society shall give careful thought and unstinted time to the duties required of them by the State and county societies. The secretary or reporter should send a report of every meeting to the Editor of the Journal as early as possible. The secretary should

send to the Secretary of the State Society a list of the delegates to the State Society and the names of the president, secretary and reporter immediately after their election. He should, before January 12, 1923, send to the printer a list of all members, with their **correct** addresses for the official list. The treasurer should send the annual dues of members for the State Society **not later than January 10**, as otherwise the member omitted is deprived of his rights and is regarded as a "delinquent."

Need of Educating the Public: It seems strange that we should have to emphasize this need after 156 years' of service rendered by the Medical Society of New Jersey to the public; after the abounding charity the medical profession has exhibited—not exceeded by any other profession or body of men—and its altruistic endeavors in preventive medicine to wipe out diseases and establish institutions for the care of thousands of sick and deformed citizens, all of which has meant large reductions in physicians' incomes. This need is now being cared for by the State Society's Welfare Committee, which is doing most excellent work, but it should have the active co-operation of every county society's welfare committee. The public is beginning to understand our aims and work for its betterment in all that relates to health conditions, and the opposition to our endeavors, therefore, is becoming less.

The Illinois State Medical Society has recently appointed a committee to organize and carry on a lay publicity campaign through the newspapers of the State. Its Journal says: "Pitiless publicity is the cult-killing corrosive. Practical, ethical publicity is the redemption of the profession. Medicine has sat silently for too long. For the sake of humanity, let this campaign flourish."

We shall refer to this method of educating the public again. In the meantime, let us sustain energetically our county societies.

President Hunter of our State Society, the Committee on Scientific Work and the Committee on Arrangement and Program are doing excellent work in preparing for our annual meeting at Atlantic City, June 21-23rd.

MALPRACTICE SUITS ARE INCREASING IN NUMBER. BETTER SECURE INDEMNITY INSURANCE.

REMARKS AT FUNERAL OF DR. M. ROYAL WHITENACK.

By Rev. Dr. William Y. Chapman.

Newark, N. J.

We have met together here today in large numbers from every walk of life and regardless of race or creed, to think, to pray, even to weep over the silent remains of the quiet, genial gentleman whom we all so deeply loved. It has been repeatedly said during the last few days that in no previous instance in this community, certainly not for many years, has there been such a universal expression of interest, of sympathy, of genuine sorrow, as during the long and terrible illness, culminating in death, of our beloved friend, Dr. Royal Whitenack. Nor has this feeling been confined to the narrow limits of the community where he was best known, nor to the greater city of which it forms a part, but it has overflowed all our borders, reported on the front page of the great metropolitan papers, until the hearts of millions have been touched.

This we must admit is very remarkable and we are not careful to give an answer to everyone who may ask a reason. Love is extra-rational, and he is cold and phlegmatic who cannot see something beautiful in this loving tribute to a friend. In this we may see a little of the answer to the heart-yearning of thousands who have earnestly prayed that God would be gracious to us that our friend might live. And some are disposed to question the ways of God and the validity of prayer. We are apt to hear again the old taunt hurled at the psalmist, writhing in his chastisements, "Where Is Now Thy God?" I can see how God may be answering prayers, not in the way we hoped, but perhaps in a better way. We have prayed that God would restore our friend, because we couldn't spare him. We could not, perhaps, we cannot see the wisdom of taking away in the prime of life, a man who has been so useful, so helpful to the suffering. No one at the time could see anything but black disaster in the death of Abraham Lincoln, but many have seen since that nothing he could have done in his after life could have contributed so much to the healing of the nation's wounds and the stopping of the mouth of rebellion, as the tragedy of his taking off. Hence, he has been called our martyr president. We must be content to allow God to know some things that we cannot know. Even the Master, the Great Physician prayed all night that the cup might pass from Him. It didn't pass and He drank it to the dregs. And that is why we are here in Christian sympathy and in Christian hope. There is tremendous truth in the paradox of His enemies, "He saved others, Himself He cannot save." And who can say that the ministry of Dr. Whitenack, beginning with this universal sorrow at his death, may not widen out through adequate memorials to remote generations?

If anyone insists upon an answer to his question, why this great outpouring of sentiment? Why this general and spontaneous mourning? I think the answer may be stated in a few words. He is mourned because he was greatly beloved, and he was beloved:

First, because of his fine personal qualities. This is not the funeral of a statesman or a warrior or a merchant prince. It is not because of any national fame or professional pre-eminence, but because of his simplicity, sincerity and unselfishness, recognized by all his associates all his life, that he is now mourned by 11 classes. You never knew a more unselfish, a more generous man, and it is to the great credit of this community that these supreme qualities are recognized and memorialized; second, he was a doctor, going about doing good like the Master Physician, not for reward, but out of sheer kindness and the love of doing good. I wonder if you doctors know how greatly you are beloved. You do not know how much you mean to our households. From my earliest recollection no visitor who ever came to the house was so welcome. The doctor always comes when he is needed, and if he is the right sort, he always brings a ray of hope and promise to the troubled home. I suppose there are bad doctors, but they are few. With whatever motives you may have entered the practice of medicine, you cannot have followed far in the footsteps of the Great Healer without gravitating into His likeness. No one can do good without becoming good. Our doctor was good; third, he was the children's doctor. Several years ago we laid away his only child, a dear little boy, and from that time Dr. Whitenack began to specialize in the healing of children. He said in effect: "I have lost my child, I will do all I can to save other children." And it was his devotion to that speciality, perhaps more than anything else, that endeared him to hundreds of families. He loved children indiscriminately. He never stopped to inquire whose child—of what race or color or creed—needed him. Nothing was a trouble to him, so long as he could mitigate pain and restore smiles to child and parent. I say that more than anything else made him widely beloved. It is the supreme hope of humanity that its reactions towards children are so generally wholesome and beautiful. One of Shakespeare's characters speaking well of another could offer no higher wish than this: "That his bones, when he has run his course and sleeps in blessings may have a tomb of orphans' tears wept on them." Nothing nobler can be said of any man than that he loved and was loved by children. The "dull cold marble" is a little less repulsive when baptized with children's tears.

Finally, our dear doctor awakened unusual interest by his brave fight for life. He was infinitely patient through his sufferings, never complaining. As long as consciousness lasted he consulted with his colleagues, who struggled so hard, exhausting all human skill, to save him. And when they failed their hearts were broken. God bless you devoted doctors. God bless you bereaved and smitten hearts. May the consolation of the Almighty be sufficient for you in this most exacting moment.

**DON'T FAIL TO PAY YOUR DUES.
DON'T FAIL TO READ OUR JOURNAL.**

ACADEMY OF MEDICINE OF NORTHERN NEW JERSEY

The stated meeting for January will be held January 17 at 8:45 p. m. After regular business is transacted a paper will be read by Dr. Henry H. M. Lyle, of New York city, on "Treatment of Disabilities of the Hand," with lantern slide illustrations.

The section eye, ear, nose and throat will meet Monday evening, January 8, at 8:45 p. m. There will be presentation of cases by Dr. J. W. Hurff, of chronic sphenoiditis, resulting in exophthalmus, and a paper by Dr. W. B. Davis of Philadelphia, on "The Correction of Nasal Deformities, With Hair-lip and Cleft Palate."

The section on medicine and pediatrics will meet on Tuesday, January 9, at 8:45 p. m. Clinics from the Newark City Hospital will be considered, with presentation of cases.

The sections on surgery and gynecology and obstetrics will meet on Tuesday, January 23, at 8:45 p. m. There will be reports and presentations of cases by Drs. H. B. Epstein, J. F. Hagerty, E. Holden, D. F. O'Connor, F. M. Paul, A. S. Harden, M. Danczis, B. H. Greenfield, J. I. Fort and C. O'Crowley.

All meetings to be held at 91 Lincoln Park, Newark.

The State Board of Health has selected Charles J. Merrell, of Bound Brook, chief of the bureau of administration of the State Health Department, as assistant director of the board. He succeeds to the vacancy caused by the death of Dr. R. B. FitzRandolph.

Mr. Merrell has been connected with the State Board of Health for many years, and is considered one of the most valuable employees of the department. He has a thorough knowledge of administrative affairs pertaining to the department and is well versed in health laws.

Deaths.

CASSADY.—At Burlington, N. J., November 29, Dr. John Bradner Cassady, aged sixty-seven years. Dr. Cassady was born in Goshen, N. Y. He graduated from the Medico-Chirurgical College, Philadelphia in 1889, and soon after settled in Burlington. He was president of the Board of Health, took an active part in civic affairs and headed the Burlington County Red Cross work during the war. He was prominent in Masonic circles.

DISBROW.—At Summit, N. J., December 25, 1922, Dr. William S. Disbrow, of Newark, N. J., aged sixty-one years. Further notice in next month's Journal.

FITHIAN.—At Camden, N. J., December 9, 1922, Dr. Joel W. Fithian, of Camden, aged 58 years. Fuller notice next month.

HALL.—At Freehold, N. J., December 5, 1922, Dr. Charles E. Hall, aged eighty-five years. After graduating from Princeton College he studied medicine, graduated from the College of Physicians and Surgeons, New York city, in 1862; he immediately enlisted in the

Union army, and after Civil War returned to Freehold, but did not continue the practice of medicine. He was president of the Freehold Banking Company from 1899 to 1904.

WHITENACK.—At Newark, N. J., December 12, 1922, Dr. Miller Royal Whitenack, of Newark.

Dr. Whitenack was born in Newark 47 years ago. At an early age he developed a liking for the medical profession. After graduating from the Newark High School he entered Rutgers College graduating in 1896; he then entered the College of Physicians and Surgeons, New York city, graduating therefrom in 1900. He served eighteen months as an intern of the City Hospital; after that he began general practice in Newark, but soon he began to specialize in the treatment of children, and continued in that branch of practice, and his skill became so widely known and the demand on his time so great that he was finally compelled to work only by appointment.

It was at the Babies' Hospital, where he was a member of the staff, that Dr. Whitenack worked under the late Dr. Henry L. Coit, a noted specialist in treatment of children's diseases, and became a disciple of the Coit methods. The result was that upon the death of Dr. Coit a considerable part of the latter's following turned to Dr. Whitenack. He was also a member of the staff of the City Hospital, being in charge of the babies' department there. Among organizations with which he was connected were the American Medical Association, New Jersey State Medical Society, Essex County Medical Society, the Practitioners' Club of Newark and the Anatomical and Pathological Society.

Personal Notes.

Dr. Charles F. Baker, Newark, and wife, closed their summer home at Bakehaven last month and returned to Newark.

Dr. W. Homer Axford, Bayonne, and wife, have returned from their summer home in Chester.

Dr. William S. Disbrow, Newark, was recently given a testimonial dinner by the trustees, faculty and alumni of the New Jersey College of Pharmacy at Achtel-Stetter's. After twenty-eight years' service he retired as professor of pharmacognogy and microscopy at the college and was made professor emeritus. At the dinner he was presented by the trustees a sapphire and platinum ring bearing the initials N. J. C. P.; by the faculty, a lamp, and by the alumni a silver loving cup.

Dr. William H. Lawrence, Summit, who was operated on in New York recently, has gone to Florida.

Dr. L. L. Mial, Morristown, recently returned on a hunting trip in North Carolina.

Dr. Victor Mravlag, Elizabeth, who retires from the office of mayor January 1, after twelve years' service, will become police commissioner the same day. He has been in official life in that city forty years, beginning as city physician in 1882.

Dr. J. Ackerman Coles, Scotch Plains, has presented to the Madison Historical Society a vase of golden porcelain, which is said to have been presented by the French republic to Washington Irving during his stay in Paris. Its appraised worth is \$5,000.

Dr. Francis E. Knowles, South Orange, and wife, are spending the winter in Aiken, S. C.

Drs. W. P. Glendon, M. F. Sewall and F. J. Love, of Bridgeton, and H. E. Löve, of Cedarville, spent their annual ten days' gunning trip in South Carolina last month.

Dr. Christopher C. Beling, Newark, addressed the Essex County Social Workers' Club in favor of the establishing of a psychiatric clinic for the county.

Dr. Clifford Mills, Morristown, returned recently from a three weeks' hunting trip in Maine, with two deer and some partridges.

Dr. C. Coulter Charlton, Atlantic City, is doing special work in nose and throat disease in Europe. He returns about January 15.

Dr. Morris A. Flower, Newark, has removed his office from East Kinney street to 1007 Broad street.

Dr. William James, Long Valley, recently returned from a deer hunting trip to Pocono Lakes, Pa.

Drs. Charles B. Smith and F. J. LaRiew, Washington, were recently elected president and trustee, respectively, of the Kiwanis Club, of that town.

Book Reviews.

All books received will be mentioned by title with the names of their authors, publishers, etc., and this will be considered by the committee as sufficient acknowledgment of the merits of the books or the interests of our subscribers to the publishers. Selections will be made for review as may warrant.

Brain Abscess; Its Surgical, Pathology and Operative Technic, by Wells P. Eagleton, M. D., of Newark, N. J., president of the American Otological Society, 1921; pages, 297; price, \$7.00. Mac Millan Company, New York city, 1922.

Until the appearance of MacEwen's classic monograph on "Pyogenic Diseases of the Brain and Spinal Cord" little was known of brain abscess and operation for the condition was seldom considered. While MacEwen's book showed the possibility of cranial surgery, little else appeared for many years. During the past two decades several men, notably Cushing in this country, have devoted much attention to cranial surgery. The cranial surgeon is necessarily limited in the number of his purulent cases. L. Bathe Rawlins, in "The Surgery of the Skull and Brain," (Oxford University Press), an excellent work of over 300 pages, gives but twenty-five pages to brain abscess.

Since most brain abscesses have their origin in mastoid, orbital or nasal accessory sinus disease, the cranial surgeon, like Dr. Eagleton, who is primarily on ophthalmologist, otologist and rhinologist, has a distinct advantage over the average cranial or neurological surgeon in the number of cases

brought to his attention. In the foreword he pays the highest tribute to Cushing, "whose genius has transformed non-suppurative intracranial surgery into comparatively safe, delicate, almost bloodless physiological procedures, has long contended that the ordinary surgical technic applicable to other parts of the body is insufficient to combat successfully the unique physiological factors and pathological changes presented within the dura; and it is Cushing's technic which the author largely has used in operating for intracranial suppuration. Surgically considered, intracerebral abscess stands in a class by itself, the problems presented in its surgical treatment differing from those of suppuration in other parts of the body and distinct from those encountered in the treatment of non-suppurative lesions of the brain."

His classification is original and is from the standpoint of surgical pathology: First, Chronic adjacent, secondary; temporo-sphenoidal, frontal or cerebellar, with a capsule; second, Acute adjacent, secondary; temporo-sphenoidal, frontal or cerebellar, without a limiting membrane; third, Intercurrent, tertiary; due to a gross lesion like sinus thrombosis; fourth, Metastatic: (a) chronic, without a capsule; (b) chronic, with a capsule; (c) acute; fifth, Traumatic.

The arrangement of the text gives the general treatise in large clear type, with operative technic and citation of cases in their proper sequence in smaller type. The book thus lends itself to rapid perusal, as well as to careful study.

Part I deals with the mental attitude of the surgeon, and general surgical technic of intracranial operations. The taking of a complete neurological history is very properly stressed.

Part II, after taking up pathological and surgical considerations, devotes a chapter each to abscess of the middle fossa, metastatic abscess, cerebellar abscess and frontal lobe abscess. Two points are particularly emphasized; the use of rubber tissue drainage, instead of gauze, and the markedly better prognosis of abscess which have a stalk. The two final chapters of Part II are devoted to hernia cerebri and the protective mechanism of the brain.

The personal element dominates these chapters, and the reader is at once impressed with the fact that the author is not only a most careful and painstaking operator, but an honest chronicler, frankly reciting his early mistakes, and warning against their perpetration by others. He confesses to a mortality of 75 per cent., but thinks early diagnosis will give marked reduction in future cases.

Part III gives a chapter each to: Diagnosis of brain abscess in general, diagnosis of temporo-sphenoidal abscess, diagnosis of cerebellar abscess, diagnosis of frontal lobe abscess.

These chapters are of greatest value to such men as the reviewer, who, when he finds he has to deal with a brain abscess, does not feel justified in operating, when the services of such a masterly technician as Dr. Eagleton are available.

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THE UTERUS AND THE CURET*

By **Albert S. Harden, M. D., F. A. C. S.**

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pital, Newark, N. J.

During the past seventeen years, in an active gynecological service, the author has been rather forcibly impressed by the indiscriminate use of the curet and by the utter insignificance in which the operation of curettage is held. In fact, it is an operation held in such little esteem by the general practitioner that only a few years ago, and maybe now, the curet was a part of the contents of the satchel during the daily rounds of the doctor. Women spoke of curettage as a cleansing or cleaning, as if it were a trivial affair that could be done in the kitchen, the following day resuming their duties. The young men who come to our hospitals for internship when they arrive at the gynecological service are very keen for curettages, feeling that as curettages are so frequently performed, they will probably have this kind of work as soon, if not sooner, than any other gynecological procedure. With this idea inculcated in the minds of both the laywoman and the medical man entering upon the threshold of practice, the author will endeavor to demonstrate that this conception of a very important procedure is fraught with danger, should not be used promiscuously and has a limited field of usefulness.

The dangers of the curet are numerous. Perforations not only with the curet, but with the dilators are numerous and many times unrecognized; but thanks to nature and asepsis, nothing serious develops. How many times, however, does

the operator light up on old tubal infection, the patient developing, if lucky, just a pelvic abscess? Again, he may perforate the uterus and partly eviscerate. This the author has seen several times. How many women date their abnormal condition to some previous curettage? We could go on ad infinitum. The curet is a valuable instrument in selected cases and when used in a proper manner by those accustomed to its uses, but it may become a dangerous weapon, the cause of much unnecessary suffering and chronic invalidism.

In 1848, Recamier, a Frenchman, brought to the attention of the profession the curet, the sharp one. Shortly afterwards, Sims, in the second edition of the *Practice of Gynecology*, severely criticised the instrument and stated that "he honestly believed that the ingenuity of man had never devised an instrument capable of doing more harm than the curet." He had a vision. He used woman's prerogative, however, and soon changed his mind, as shortly afterwards he himself produced the Sims curet and highly recommended its use. Later Thomas introduced the wire curet, and Simons the spoon-shaped one. This then was the beginning of the era of intra-uterine instrumentation, although intra-uterine medication was and had been practiced for year. In fact, it was spoken of by the Hindoes many centuries ago as clysters. About 900 B. C., Sorannus and others spoke of the speculum, which was of the bi, tri and quadra-valved type, but not one word concerning a curet or similar instrument. With the very prevalent use of the curet at the present time, with its seeming numerous indications, one is but forced to wonder whether women before the advent of the curet were fortunate or otherwise; they must have had similar conditions and similar

*Read before the section on gynecology and obstetrics of the Academy of Medicine of Northern New Jersey, October 24, 1922.

indications. It is the intention of the author to put before you briefly a few of the numerous conditions, as well as the most common for which the curet is now used. Time forbids me mentioning all, for the curet to some is the panacea of all female diseases.

The first condition is that of Sterility. Here, indeed, is a field, the antithesis of a happy union. How many women have undergone the operation of curettage for this condition, so that their maternal longings may be gratified, their husband or family appeased? Some one is to blame for this distressing condition. The husband says that he is all right, so he is not examined, or if he is, a condom is used, a procedure of little value, even for viability of the spermatazoa. The woman is examined and a diagnosis is made that the womb is not open wide enough to admit the male organism (an organism smaller than a red corpuscle in diameter). The woman undergoes the curettage, but still no offspring, although the physician declares the operation a success. On the other hand, a few days after the trivial (?) operation, the patient develops a chill, fever and pain in lower abdomen. A mass develops posterior to the uterus. One of two things has happened: Either the attending has infected his patient, which is by no means uncommon, or else a dormant infection of the tubes, probably an infection from the husband has been stirred up. What are the chances of a family now? We are lucky if we save the patient, and still more so if we do not make her a chronic invalid. I am not drawing an imaginary picture; this condition of affairs occurs daily and I have seen numerous just such cases. Other very frequently seen conditions, and for which the curet is used, but with poor ultimate results, as far as sterility is concerned, are the acutely ante-flexed uterus and the infantile uterus. Both of these conditions are due to a faulty development. In fact, in the former a curettage does more harm than good; what little mucous membrane there is, is scraped away, with a resulting formation of scar tissue. The same may be said of the infantile uterus. Far better in these conditions to simulate nature by stimulating the growth of muscular tissue by the insertion of a foreign body, whether it be a glass plug or iodiform gauze, it matters not, so long

as we can stimulate contractions of the organ; but leave the curet aside. A very frequent cause of sterility is a sacculation of the cervical canal caused by a stenosis of the external os plus an endocervicitis. The mucous forms behind the structure and fills the canal with tenacious mucous. This, not the stenosis; forms a barrier for the spermatozoa. This condition is curable, but not with the curet, although frequently used. Leucorrhea of cervical origin is a very frequently curetted condition, which, however, is not amenable to the curet. And so, I could go on indefinitely, however, time does not permit. Permit me, however, to say, don't always blame the woman for a sterile marriage. Sixty-five per cent. of all sterile marriages are due directly or indirectly to the male. Furthermore, I know of no pathological condition causing sterility that is amenable to the curet.

Dysmenorrhea, or as Massey suggests, menorrhagia, is a very frequent indication for curettage. It is treated as a disease and not a symptom. There are two forms, primary and secondary. In the primary, pain may occur without any demonstrable pelvic lesion, while the secondary is accompanied with associate pelvic conditions. Kelly divides dysmenorrhea into the spasmodic and congestive forms from the character of the symptoms. In the spasmodic form, the pain starts just before or exactly as the flow starts. The character of the pain is sharp, colicky and paroxysmal; while in the congestive form, discomfort may begin a week before, being dull in character accompanied, at times, with nausea and vomiting, lassitude or extreme weakness or nervousness. Although a most careful study of the spasmodic form has been made, the most accepted theory, which, by the way, was given great credence by Marion Sims, Sir James Simpson and Barnes, is obstruction of the cervical canal. In fact Sims stated that "there can be no dysmenorrhea, if the canal of the neck of the uterus be straight and wide enough to permit a free passage of menstrual blood," while Barnes stated that "the essential condition of dysmenorrhea is a retention of menses." The above theories have been severely upset by numerous observers. A sound could be easily passed into a menstruating uterus, a widely patulous cervical canal, yet accompanied with

severe pain, a profuse menstruation with very severe pain. When we consider that the average loss of blood during menstruation is only two ounces a day, about forty drops per hour, or two-thirds of a drop per minute, it would seem that an obstruction sufficient to cause pain from such a small amount of blood would cause a complete, instead of a partial, obstruction. Are not the theories then of Sims and Barnes rather inconceivable? Shultz and Novack, on the contrary, think that the pain is due to a "capsular distention." In other words, the normal or mature uterus contains a preponderance of muscle tissue over connective tissue. The immature uterus, on the other hand, has a preponderance of connective over muscle tissue in a ratio of two to one. When menstruation occurs there is a capsular distention of this connective tissue layer, in which layers, the bloods are contained. There is a stasis of the uterine veins, which, in turn, give rise to a pressure stimulation of the uterine nerves, causing the spasmodic, labor-like contractions, which, in turn, cause the pain. There are three other forms of dysmenorrhea (primary) that are but little understood; nervous, neuathenic and neuralgic. They all occur, however, in neurotic women and especially so in the pampered class. The curet in all these forms is of little or no value. There are a few that are relieved, a number given temporary relief, but by far the great majority of the spasmodic types are not even relieved. Holden, in an analysis of ninety-five patients, one to twelve years after dilatation and curettage, found that 40 per cent. were wholly or very greatly relieved for one year, of which 7 per cent. had a recurrence after the year; 30 per cent. had no relief at all, while the remaining 30 per cent. had slight relief for a month or more. Of this series, twenty had maldevelopment of the uterus. In only 25 per cent. were they even relieved. I again wish to emphasize the fact that, contrary to popular belief, antelexion of the uterus has but little to do with dysmenorrhea, and, if it does occur, it is coincidental. In the secondary or congestive forms, the causes are numerous. They may be the result of any inflammatory disease of the pelvis, numerous constitutional diseases such as diabetes, nephritis, syphilis, tuberculosis, rheumatism or cardiac disease, and

chlorosis or its kindred blood conditions. Retropositions of the uterus are by far the most common condition, however, as far as the general practitioner is concerned, and on which the assault of the curet is most frequent and where the dilators frequently play havoc, perforating the anterior wall of the uterus and sometimes the bladder. I have seen several such cases. Judd, in 176 cases of retrodisplacements, found dysmenorrhea in 59 per cent.; in nullipara, with displacements causing symptoms, 86 per cent. had dysmenorrhea. In about 90 per cent. of all cases of dysmenorrhea, according to Holden, one of three conditions was found to be the cause, pelvic inflammatory disease, retrodisplacements of the uterus or myomata. Contrary to popular belief, chronic endometritis is a very infrequent cause of dysmenorrhea, in fact, it is rather a rare condition. Cullen, in a series of 1,800 microscopic examinations, found true chronic endometritis in only forty-eight cases. Holden found the cause of dysmenorrhea in 11 per cent. of his series to be due to myomata; Kelly in 25 per cent. Now, while it is true, that the majority of cases of retrodisplacements have a hyperplasia of the mucous membrane, the retrodisplacement by causing a passive congestion of the entire uterus is the cause of the hyperplasia. To curet such a condition without correcting the cause is an error of judgment, and yet it is frequently done. Some surgeons do a preliminary curettage before a suspension operation. My personal belief is that it is unnecessary, increases the time of the operation and increases the risk. The correction of the cause cures the hyperplasia. I cannot see where the curet has any field of therapeutic value in the treatment of dysmenorrhea. Rather, we should seek the cause assiduously, treating that rather than treating a symptom, subjecting our patient to an operation, with but little assurance of much relief.

One of the most frequent, if not the most frequent, uses of the curet is in the treatment of incomplete abortion. While we admit that there are cases now and again that require our assistance in the removal of detritus, my contention is, that nature is not given half a chance to do what she is willing and able to do. Abortion is a very frequent incident in the life of the female, although, as you

must readily realize, no accurate statistics can be given. Yet, taking several large clinics, we find the following: Hagar, 1 abortion to 8 labors; Edgar, 1 abortion to 15.7 labors, while De Lee in his private practice found 24 per cent. abortions. The most frequent time for abortion seems to be between the eighth to twelfth week of pregnancy, Edgar's statistics giving 23.91 per cent. The relative frequency of causes is: First, diseases of the endometrium; second, retrodisplacements; third, syphilis; fourth, toxemias; fifth, criminal interference, and sixth, low implantation of the placenta. While I realize that there are as many men in favor of a rapid emptying of the uterus in this distressing condition, I still maintain that the only indication for assisting nature is uncontrollable hemorrhage. Both De Lee and Williams recommend the thorough packing of the vagina, and if necessary the uterus, under the strictest aseptic precautions, with iodiform gauze. This will, in the very great majority of cases, control the bleeding. Pains will be induced with an expulsion of the contents of the uterus within from twenty-four to thirty-six hours. Both are opposed to curettage. Edgar, on the other hand, fully believes in emptying the uterus, although warns of the dangers of the curet. As far back as 1848, T. T. Burke, in accouchers Vade-Mecum, stated that "the afterbirth did not always come away at once, but, that nature generally removed it in a short time." Robert Barnes stated in 1874, in the Medical and Surgical Diseases of Women, that he believed that "it was only necessary to obtain and maintain the patulency of the cervical canal. At the present time this mode of treatment is vigorously advised by Pollack, who has repeatedly demonstrated to his class the absolute impossibility of thoroughly removing the contents of the uterus. After hysterectomies he has curetted the hard uterus, opened same and shown the membrane only removed in strips. He states that, when, after a systematic scraping we find this condition, how much more difficult is it to remove detritus in a large boggy uterus. He likens the inside of a puerperal uterus to a large open wound, which heals as other wounds heal, with round cell infiltration acting as a barrier to invading organisms, if the uterus be left to itself and this barrier be not

disturbed by instrumentation. He treats by giving plenty of drainage, with the stimulation of uterine contractions. The former by the Fowler position, the latter by some preparation of ergot or hydrastis. Only in cases where there is dead material, with the presence of gas-bacillus, does he interfere. He absolutely prohibits any member of his staff entering the uterus with finger, curet or forceps. Mortality and morbidity have decreased in proportion. De Lee believes that it is just as rational to curet a diphtheritic throat as to curet a septic uterus. We believe, in the septic uterus, that the Carusa treatment (2 ounces of a 20 per cent. alcohol solution injected through a special tube into the uterus, after tube has been surrounded with iodiform gauze), is the best treatment, but do not use any intra-uterine instrumentation. May I reiterate? The curet should never be used in a septic uterus, and the curet should not be used as the treatment of election in any abortion case, but, rather, as a procedure of last resort, all other conservative methods having failed. One will be surprised at the infrequency of the necessity for its use.

Endometritis, not a disease in itself, but, rather an effect, may be divided into three types: First, infectious, the result of microbic invasion; second, chronic interstitial, the result of previous infection; third, glandular hypertrophy, commonly known as hypertrophic endometritis, the result of circulatory changes. The first is generally secondary to puerperal sepsis. The most frequent organisms attacking the endometrium are the streptococcus and gonococcus, but only rarely attacking, except in the puerperal state. It is possible, however, to carry infecting organisms to the endometrium by dirty instruments, or the curet, from an infected cervix. The second is little understood, the endometrium thickened and there is a marked infiltration of round cells. A curettage in these cases may light up a dangerous latent infection. In the third variety, I have already spoken about under dysmenorrhea; curettage does not cure, remove the cause and your hyperplasia disappears.

Malignant disease of the uterus are not amenable to the curet. If one suspects malignancy of the body of the uterus, the curet as an instrument for diagnosis is invaluable, providing an

early or immediate removal is contemplated. Here we open avenues for the dissemination of cancer is my firm belief. It is by no means a proven fact that cancer travels only by the lymphatics. In cancer of the cervix it is absolutely useless unless used preparatory to the use of radium or used as a palliative method, otherwise it hastens the end.

In conclusion let me state that the curet as an instrument of therapy is of very limited use. Even in skilled hands it is a dangerous instrument; its promiscuous use is to be severely condemned.

THE TREATMENT OF HYPERTENSION IN CARDIO-RENAL DISEASE.*

By **David Riesman, M. D.,**
Philadelphia, Pa.

Death comes in different guises, but for most of us in the medical profession the thread of life runs along an artery or in the walls of the heart. It may be snapped suddenly or it may be stretched and pulled until it gives way gradually, strand by strand, so that the end is "but a sleep and a forgetting." After death, the pathologist, with his scalpel and his microscope, can usually determine the place where Atropos cut the thread, but the "why" often remains a mystery. We see disease of the heart and we find disease of the kidneys and consider either one or the two jointly as adequate cause of death; but what initiated the disease process in the arteries, in the kidneys, is rarely revealed by post-mortem study. And even clinical investigation has so far not solved the mystery.

If cardio-renal disease were as definite a condition as locomotor ataxia or typhoid fever, the problem would be comparatively easy, but such is not the case. We are often unable to determine in a given case of cardiorenal disease what the relation of the heart and the kidney in the sense of priority on the part of the one or the other may be. It may, perhaps, help us in diagnosis, in prognosis and in treatment if we consider somewhat in detail the various possible relations of the heart and kidney in disease.

*Read by invitation before the Academy of Medicine of Northern New Jersey, May 11, 1922.

1. In chronic affections of the myocardium, with or without endocardial or pericardial involvement, the stage of decompensation is accompanied by dropsy and by albuminuria. As a rule, the albumin is small in amount; but at times, a considerable quantity, with granular and hyaline casts, is present. The phenolsulphonephthalein test, in addition, shows a diminution in functional activity on the part of the kidney. Students, hospital internes, and even many practicing physicians, look upon these disturbances of the kidney evidenced by albuminuria, cylindruria and a lessened output of the dye, as constituting nephritis; hence, by inference, upon the whole picture as a form of cardiorenal disease. Neither from the pathologic nor from the clinical point of view, however, is that a correct interpretation. It would be just as logical to speak of cardiopulmonary disease in such cases, because there is edema of the lungs; or of cardiohepatic disease, because the liver is enlarged. The albuminuria is due to passive congestion and the chemical and physical changes incident thereto, and, perhaps, to alterations in oxygen tension in the blood. It may be difficult to prove that there is no true nephritis; but anyone who has seen the complete disappearance of all renal manifestations with restoration of cardiac function will be convinced that in such cases there has been no real nephritis. I have known patients to be put into hot packs, and, thereby, in jeopardy, because the urinary signs were interpreted as Bright's disease, and the myocarditis either overlooked, because of the absence of a murmur, or underestimated in importance.

At the bedside one may be helped in getting the right viewpoint by the following criteria:

(a) A history of cardiac distress, especially of shortness of breath, dating back some time.

(b) Repeated similar "breaks" in health.

(c) High-colored and concentrated urine, throwing down a heavy, pinkish deposit of urates.

(d) Only a moderate increase of non-protein nitrogen in the blood.

(e) A moderate, but not extreme, diminution of phenolsulphonephthalein output.

The arterial tension in this type has

nothing characteristic about it. It may be high or low, depending upon conditions outside of the kidney. Whether high or low, the treatment must be directed to restoring the circulation, which is best accomplished by rest, proper diet, adequate catharsis, and, above all, by the use of digitalis. Hypertension may be associated with cyanosis and evidences of general venous stasis, with enlargement of the heart's dullness toward the right, etc. The best treatment for the hypertension in such cases is venesection. One should be careful not to overlook pleural effusion, hydrothorax, which sometimes comes on very insidiously and which, while it lasts, may prevent any improvement from the use of digitalis or other drugs.

2. A second type of cardio-renal association is presented by that intensely interesting, but universally dreaded disease, **subacute septic endocarditis**. Through the work of Baehr, Libman, Ophulus and others, we have learned to recognize a special form of nephritis secondary to the heart affection and dependent upon it. It seems to me that one could without hesitation apply to this condition the term "cardio-renal disease"; for the kidney involvement is distinctly inflammatory, has characteristic histologic findings, and plays a prominent part in the later stages of the affection. It is far more than a mere incident in the course of the disease. The treatment in this condition concerns itself, as a rule, with the primary infection of the valves, and possibly the secondary foci in other organs, and rarely takes account of any hypertension that may be present.

3. A third form of combined heart and kidney disease is that most frequently referred to as cardio-renal disease, although we may properly call it renocardiac, if we want to express by a compound word the antecedent and the subsequent. The primary condition is a glomerulonephritis, primary at least with relation to the heart. The nephritis in some way leads to hypertension, which increases progressively as the renal disease advances. Cardiac hypertrophy, often of an extreme degree, and arteriosclerosis are phenomena secondary to the hypertension and perhaps compensatory in nature. When fully developed, the term cardio-vascular renal disease is applicable. The

cause of glomerulonephritis is often undiscoverable. Heredity and focal infections seems to play a part. The disease is most common between the ages of thirty and forty-five years, although I have seen it as early as nineteen and as late as after fifty. The patients have a peculiar sallow, pasty complexion, which has been compared to the color of cold buckwheat cakes. The arteries are very much thickened, and the tension is extremely high. (In very rare instances, there is hypotension). The heart is markedly enlarged, and the aortic sound greatly accentuated; at the apex there is usually a gallop rhythm of the anapest type, sometimes a systolic murmur is heard at the aortic area, as well as over the mitral valve. The prognosis is bad, death commonly occurring from uremia, sometimes through pressure by a hemorrhagic pericardial effusion.

A study of the blood shows evidences of a very marked retention of the nitrogenous waste products. After the injection of phenolsulphonaphthalein, the kidneys may fail to eliminate any of the dye or they eliminate but a small percentage. The treatment cannot stop with the hypertension alone; though the pressure may reach such proportions that, in order to prevent apoplexy, which is a rare event in this affection, a large amount of blood must be promptly withdrawn. The essential treatment consists in getting other organs to do the work that the kidney is unable to perform. This is done by means of sweating and purgation. As profuse perspiration in this type of case is apt to raise the concentration of non-protein nitrogen in the blood, as has been shown by Pepper, it is important, during the diaphoretic treatment, to give large amounts of water. Purgation is best accomplished, in the ordinary case, by the use of the salines. When uremia is threatening, I have found elaterium to be one of the best detoxicating agents.

The diet should be largely lactovegetarian, with a small amount of animal food. There is not much to be said about the use of drugs; for, except as palliatives, they have very little value. One of the common complaints of this type of cardio-renal patients as that of nocturnal dyspnea, for which nitroglycerin or some other nitrite, such as erythrol tetranitrate, is a quickly acting remedy.

4. The next form of hypertension is

one that has given rise to a good deal of controversial literature. I need only mention its popular name of "essential hypertension" to bring to your mind the debate that has been going on for years as to the nature of the condition. The very name—essential or idiopathic hypertension—is a thinly disguised admission of ignorance, nor is the term vascular hypertension much more illuminating. The outstanding feature is a high blood pressure without demonstrable disease of the arteries, at least as far as the accessible ones are concerned, and without manifest disease of the kidneys. The bone of contention, however, has been the kidney. Many authorities, among them the late Theodore C. Janeway, contend that in all cases of so-called essential hypertension, particularly when the pressure is above 200, the kidney is a factor of great importance. Another group with which I have always ranged myself believes that hypertension may exist without any primary or even committant disease.

The chief distinguishing features, and concerning these both sides agree, are: the patients are usually stout or fat, free from syphilis, and, if women, at or past the menopause; the systolic pressure is from 220 to 250, or even higher, the heart is enlarged, the blood vessels soft, the urine usually normal. Even the blood chemistry shows no striking departure from the normal, except in advanced stages; the eye grounds as a rule are free from noteworthy changes. A systolic murmur at the right base is a common finding. A certain proportion of cases show changes in the kidney at autopsy, but it is just as reasonable to assume that these changes are secondary, as to consider them the cause of hypertension. One gets the impression in studying a series of cases that the primary factor is some vasoconstrictor agent and that arterial thickening, if present, is secondary to the hypertension. The cardiac hypertrophy is a compensatory phenomenon.

If we look for the source of the vasoconstrictor agent, we enter the field of speculation. The striking fact that many cases occur about the time of the menopause suggests that the basic agent is of endocrin origin. Before this audience I need not dwell upon the general vagueness of our knowledge of this subject,—

a vagueness that little justifies the wealth of dogmatic statement with which our medical literature is burdened, especially that supplied with such touching generosity by the manufacturers of endocrine products.

There is an additional reason that makes me doubt the primary renal origin, namely that life terminates seldom by the renal route, but usually through progressive circulatory failure or through apoplexy.

5. Arteriosclerotic hypertension: There is a prevailing belief that arteriosclerosis and hypertension are synonymous terms, but no one with hospital experience can fail to see many cases of arteriosclerosis with normal or even low tension. There is a type in which the arteries are not beaded or atheromatous, but firm and leathery, like stiff, thick-walled tubes, in which high tension is an invariable accompaniment. This form of arteriosclerosis is commonest in men after the age of 50; it has a great tendency to involve the cerebral arteries, the retinal arteries and the arteries of the kidney. In the end the picture is that of cardiovascular-renal disease, with the renal disease less evident than in those cases that start as glomerulonephritis.

The true cause of this affection is not known. Syphilis plays a part, but is neither the sole nor the dominant factor. The cause may be a toxic substance arising in the intestinal canal or it may be that obscure condition—of the existence of which the clinician is conscious though he cannot put his finger directly upon its essence—the condition that we call gout or lithemia. The victims of the affection are very often strenuous, dynamic men, who for years have carried great responsibilities, have smoked heavily, and have taken but little care of their health. While the kidney eventually suffers death is usually brought about through a vascular crisis, either apoplexy or angina pectoris, rarely through uremia.

Treatment.—In taking up the question of the treatment of hypertension in connection with cardiorenal disease, it is important to point out that it is necessary to look for focal infections, which though they may not initiate the process, may play a part in it. Such foci at times exist in the tonsils, the teeth, the sinuses, the gall bladder, the appendix, the prostate gland.

The patient with hypertension and disease of the heart and kidney, should realize that his field of action must be restricted; that there is danger ahead if he ignores the warnings of the disease or of the doctor. He or she should arrange for a routine physical examination two or three times a year or oftener, a type of preventive medicine that ought to be more widely adopted and for which we ought to make active propaganda. In advising restricted activity, one must be reasonable,—one must, as Jeff says to Mutt, "use discretion." For instance, it would not be to the best advantage of an energetic business man to be taken entirely out of business, unless his case is far advanced. It may be sufficient to induce him to take a vacation. A simple procedure that frequently proves beneficial is to have the patient place a couch in his office on which, under proper privacy, he may rest for an hour after his luncheon or whenever he feels fatigued.

The patient must guard against sudden accesses of pressure which may come through anger, strain, or coitus. Proper action of the bowels is essential. It does not follow that an individual who states that his bowels move regularly once a day has adequate elimination. Indeed, frequently such persons are actually constipated. There are several measures that have proved useful to me in securing proper action of the bowels. One is an occasional dose of castor oil, once a week or once in ten days, an ounce of oil. The patient should take the oil in the evening without eating his customary supper. Another procedure of value is intestinal irrigation, using many gallons of water. When possible, I send the patient to an institution where men and women, schooled in the practice of giving irrigations, may be found. Some patients do well by taking once in ten days a blue-mass pill, following by a saline. This method is especially useful if the patient objects to castor oil. It should, however, not be employed when there is marked evidence of kidney irritation.

The high frequency current has been used for the reduction of blood pressure, although it is perhaps a little less popular than it was a few years ago. Cabinet baths are helpful, but must be employed with circumspection. If the patient is relieved, continue them, but if he experiences any discomfort, a sense of fullness in

the head while in the bath, then it is better to abandon the procedure.

Diet.—There are two subjects, two at least, upon which the medical profession possesses very little reliable information, namely diet and climate. Perhaps the contradictory advice given to patients upon these matters is no small factor in the general skepticism regarding medical opinions. Sometime ago I was preparing a lecture to my students on arteriosclerosis; I looked up the literature on the dietetic treatment and found good authorities recommending the exact opposite. One group prescribed carbohydrate-free diet, the other made carbohydrates the main constituent of the diet. We shall probably never have exact mathematical data upon diet for it is a subject in which personality, heredity, environments and many other factors play a part, but more enlightenment is very necessary and is sure to come.

I have always felt that the patient with high blood pressure does better on low protein than on high protein diet. Some have gone to the extreme and cut out all animal food. This is not only a severe punishment to the average patient, but also tends to weaken him, to lessen his general resistance. Mosenthal, of New York, and Strouse, of Chicago have shown by careful observation that proteins do not raise the blood pressure in high tension cases. Strouse, indeed, found in several instances that a high protein diet—2 gms. per kilogram, was sometimes attended by a fall in blood pressure. It is a question, however, whether a patient outside of a hospital, eating his fill of meat, would do as well as he would on a restricted diet. At any rate, it seems to me unwise to make no restriction on the normal amount of animal food taken by the average patient. My advice has always been not to eat meat oftener than once a day or once every other day, and under meat I include any kind of meat. The amount should always be small,—a little chicken, a lamb chop, a small piece of cold lamb, roast beef, or fresh fish, according to the patient's preferences. Many hypertension cases suffer from flatulence and hence do better if the starches are reduced. Such restriction is particularly advisable in the overfat patient.

Perhaps more important than any particular dietetic constituents, than the qual-

ity of the diet, is the quantity. Many patients with hypertension are habitual overeaters. They suffer from what Allbutt has called hyperpiesis. Such patients find themselves better if they reduce the amount of food taken in a day. They may take for breakfast a little fruit, a small dish of cereal, or one egg, and a little tea or coffee. At noon, which should, if possible, be the heaviest meal, the patient may have a chop or some other meat in small amount, two green vegetables and some stewed fruit or sour milk or junket and a slice of toast or zwieback. The evening meal should be simple,—oysters or oyster broth, celery and a baked apple. If the meals as herein sketched—they permit of variations within fairly wide limits—prove inadequate, the patient may have at ten and four a glass of buttermilk.

Exercise.—The best form of exercise is golf. It takes the patient out-of-doors and precludes the possibility of his thinking of his worries. In advising it, the patient's life-long habits and practices should not be left out of account. I have known elderly men to become so enamoured of it that they played it to excess and seriously damaged their circulation. It is well, I think, if the patient reports after his first game. On the whole, however, it is a safe sport, unless there are untoward symptoms. The patient may be allowed to play it in moderation once or twice a week. Caution should be exercised in using the cold shower. Walking is a good substitute for golf, when that is not feasible. Massage is also useful when for one reason or another the patient cannot take exercise.

The rest cure is advisable in some patients having hypertension in association with cardio-renal disease. The selection of the proper type of patient requires a good deal of judgment and experience, there being no rule of thumb to guide us. I have found that when I make the proper choice, the patient feels better at the end of the first twenty-four hours of her rest cure and shows a decided reduction in blood pressure, better kidney function and a slower heart rate.

Drugs.—As long as we do not know the cause of hypertension as a primary disease or in connection with nephritis, a specific therapy is impossible. The cases that occur at the menopause are

sometimes made better by the use of organic extracts, the ovarian substances, sometimes thyroid extract. Perhaps the future treatment of these cases lies in that direction, but just at present it is in a rather inchoate state. The nitrites do not lower blood pressure permanently, but are useful as temporary vasodilators. To show that the nitrites are not efficacious in lowering pressure permanently, I will cite a case I saw only a few days ago. It was a patient with diabetes, hypertension and ocular hemorrhages. The family physician told me that the blood pressure had come down from 220 to 200, under the use of large doses of nitroglycerin. We took it again and found it was 230, notwithstanding the fact that the patient had been given five tablets of 1-100 grains each, three times a day.

For the relief of special symptoms, such as nocturnal dyspnea, anginoid pains, etc., the nitrites are useful remedies. I have found erythrol tetranitrate sometimes efficacious when the other nitrites had failed. The iodids do not materially lessen tension but they may in some way keep the pressure under control by reducing the viscosity of the blood.

When the pressure reaches dangerous heights, nothing is so useful as bleeding. I have found in some instances that bleeding from the arm was difficult on account of the great viscosity of the blood and did not produce the desired effect. In such cases leeching from the temporal region or the mastoid process has given much better results.

Among many medical men, there has been a fear of using digitalis in cases of high blood pressure. Digitalis does not raise blood pressure in hypertension cases and is certainly indicated when there is any sign of cardiac weakening, regardless of the blood pressure.

In this address, to which you have listened so patiently, I have not tried to be all-inclusive, for the subject is one of the vastest in the whole realm of clinical medicine. I hope, however, that I have covered some of the main points in which as practicing physicians you are interested.

Father was about to ask the blessing and every head was bowed. Silence reigned. Just then the telephone rang and Father promptly said, "Hello."

AUTOSUGGESTION.*

By Talbot R. Chambers, M. D.

Jersey City, N. J.

So many people are talking and thinking of autosuggestion it seems eminently proper that the medical profession should investigate the subject. Two books occupy the center of the stage today. "Self-Mastery, Through Autosuggestion," by Emile Coue, and "The Practice of Autosuggestion by Coue's Method," C. Harry Brooks, the author.

Coue claims the education of the child should begin before its birth; that if a woman, a few weeks after conception, makes a mental picture of the sex and qualities, moral and physical, she would wish in the child which she is going to give birth to, and, if she will, during gestation, continue to impress them on herself, the child will have the sex and qualities desired. He notes that Spartan women bore warriors, while in Athens the children had intellectual qualities one hundred fold greater than physical.

His claims for bringing up children are such that if adopted by the parents and guardians, the homes of our land would produce a race with the highest moral and physical qualities. Never tell the child you will be sick, will fall down or have some other misfortune; do not provide adverse suggestions; do not saturate their impressionable mentality with "naughty," "disobedient," "stupid," "idle" or "viscious" terms, but rather suggest happy, uplifting appeals to their better emotions.

He says two absolutely distinct selves exist within each of us; the conscious and the unconscious. This latter generally escapes notice. The unconscious, or, in other words, the imagination, makes us act even against our will when there is antagonism between these two forces. The unconscious presides over all the functions of our organism. A knowledge of autosuggestion is indispensable to doctors and instructors generally in order to practice it and provoke in others good, rather than bad suggestions.

The will always yields to the imagination. For example: A plank one foot wide and thirty feet long, placed on the ground, is not difficult to walk on from

one end to the other. Place the plank at a dizzy height and one would find it almost impossible to walk many steps. Riding a bicycle, an obstacle is seen ahead, the impulse is to rush at or over it. One wants to remember a name, but cannot. One wants to sleep, but cannot. The drunkard drinks against his will in spite of the harm it will do. All these illustrate how the imagination gains the victory over the will. The criminal says: "I couldn't help it, something stronger than I impelled me to do it."

Autosuggestion requires that the unconscious must be made to appropriate and assimilate a suggested train of thoughts. Coue really hypnotizes his patients by the old method with which we are all acquainted and need not be dwelt on here. I do not think it would be wise for the people generally to attempt this procedure. Autosuggestion is a dangerous instrument. It can wound and even kill if handled imprudently. Coue claims if our unconscious self is a source of many ills, it can also bring about the cure of many physical and mental ailments.

Certain people predict correctly that on a certain day and under certain circumstances they will suffer a sick headache. Some imagine themselves ill in mind or body, others in exactly similar circumstances are happy.

He tells the sufferer you will not be sick, you will have a good appetite and good digestion, you will defecate at a specified time in the morning after a good sleep and you will be happy. Then he compels them to repeat the sentence: "Day by day, in every way, I am getting better," twenty times night and morning. The "in every way" includes the complaints from which the patient suffers, in mind or body. The patient does not necessarily dwell in his thoughts on the trouble whatever it may be, but on the idea that he or she is getting relieved and happy again.

The application of his idea for doctor's use in prescribing seems to me most sensible and practical. The medicine necessary is prescribed, but the idea is added that what annoys will have disappeared. If the doctor has to prescribe for what he knows to be a fatal ailment he does not bluntly tell the patient, but rather says to the patient: "You are seriously ill, but with patience you will be better."

*Read before Hudson County Medical Society, October 3, 1922.

This idea of autosuggestion if introduced into reformatories, Coue says, would reclaim 50 per cent. of the vicious children. No one can say what good might be done in the jails with the idea.

In regard to physical changes, which may be brought about, I cannot cast aside as totally valueless his idea. He says the unconscious is aroused by the autosuggestion in cases of a fibroid tumor. "It must go. It is to go." The brain orders the arteries supplying the tumor to contract and contract they do. The tumor suffers loss of nourishment and diminishes in size. He would have to prove this to me. I can readily understand how the numerous list of asthmatics have been relieved, but doubt if hay fever could be brought under suggestion.

Imagination or thought force is one of the greatest gifts to mankind. How far would the artist, the sculptor, the dramatist, the author or the doctor progress without it. Rochester, Minn., would be an unknown village today if it hadn't been for the dreams of the Mayo brothers. The child with his Santa Claus dreams is many per cent. happier than the child without them and has a larger horizon, too. The adult is but a child with larger possibilities.

Teamwork by the doctor and nurse, suggesting the good to the patient, are doing much, very much more than simply following out cold, practical steps, in curing the patient.

You and I have seen many cases of eye, nose and throat ailments in which the future has been endangered by false ideas about tuberculosis, syphilis and cancer. I have seen a man die of false hydrophobia.

The tendency to go wrong is an autosuggestion, and if we may be able to change the direction to good, we are within our rights and privileges and should try it out on every occasion.

Now, I don't know whether this is the creed of the so-called mental healers, but there are ideas in the Coue and Brooks' system which I have found helpful in my practice, and which I am sure every man in this meeting could use to advantage for himself, his family and his patients.

MENTAL ABNORMALITIES AND THE PROBLEM OF EUGENICS.*

By Alfred Gordon, M. D.

Philadelphia, Pa.

Under the term of mental abnormalities, I propose to comment briefly upon a very large field of deviation from normal in the psychic sphere. The lowest forms of intellectual development will be considered first. Gradually the higher normal types will be mentioned. Next in order, I will describe the irregular psychic forces in the psychopathic individuals, which manifest themselves in a great variety of abnormal phenomena. Finally the great problem of insanity, with their causes, will be given due consideration. Such a study will logically lead us to the subject of Prophylaxis or Prevention of Mental Abnormalities, and consequently to the problem of Eugenics.

In considering all varieties of mental deficiency, we find a long scale, beginning with mental monstrosities and ending with slight mental feebleness. When the intellectual powers are involved in their entirety we deal with idiocy. When the arrest of mental development is only incomplete and is, therefore, compatible with the existence of some intellectual manifestations, we deal with imbecility. There are also those in whom only certain powers are likely to reach a degree of development; in whom there is no general, but only partial defect of intellectual powers. For example, one shows a meager power of intellectual acquisition, in another the power of judgment is defective; another is incapable of acquiring elementary mathematical knowledge; in another the power of attention remains very elementary; others show a marked poverty in the power of reasoning, of generalizing, of abstracting, of memorizing, of associating ideas. This category of individuals manifests a conspicuous inequality of development of various intellectual powers. The complete absence of intelligence, or moral conceptions, of sensibility, places an insurmountable obstacle between idiots and the exterior world. Education has no hold on them, impressions leave no trace in them. Instinct

Measles' Epidemic.—There was an epidemic of measles in most of the towns of Gloucester County during January.

*Read at the November meeting of the Cape May County Medical Society, November, 1922.

alone guides their actions and their relation to others. Their life is reduced to an automatic execution of vegetative function.

In imbecility we find rudiments of intellectual and moral development. The intellectual niveau is somewhat higher than in idiots which, therefore, permits certain acquisitions. With considerable amount of patience, perseverance and ingenuity one may succeed in training imbeciles in certain moral principles. In spite of all efforts one can expect but a certain degree of mental development in an imbecile. His language remains poor, as to the number of words; his articulation is defective; his expression indicates poverty of thought, the character of his acts corresponds to his manner of thinking. In the sphere of mortality he exhibits instinctive tendencies of a low order. Cruelty, vanity, gluttony, masturbation, sexual perversion, excesses of all kinds, cowardice, unusual irritability are all characteristic of imbeciles, and these characteristics lead frequently to all sorts of abnormal acts. Theft, arson, brutality, homicide are not uncommon in imbeciles. Following up the intellectual niveau one step higher than in the imbecile, we enter the domain of the large group of mental feebleness, the study of which is of considerably higher importance from sociological and legal viewpoints than of that of idiocy and imbecility. Here we meet with a great many varieties and subvarieties and the transition of one into the other is imperceptible. This is the most important chapter in the study of mental deficiency, as the number of such individuals is legion. We find them with us frequently, we deal with them in innumerable transactions, we find them on school benches, as well as in business life. Their relation to the community frequently results in harm. This group presents, speaking generally, a mentality inferior to the normal in quantity and quality. Their intellectual development is both delayed and reduced. The slowness of mental evolution and its lesser amplitude are characteristic. Thus, for example, the intelligence of a boy of twelve resembles that of a child of five.

In view of the enormous influence of intelligence upon the shaping of the normal personality, the resulting moral debility is to be expected. It is a common observation that, apart from idiocy

and imbecility, one of the chief characteristics of the feeble-minded is an obtuseness of conscience. The elements of the latter are too feeble in the struggle against passions. It may happen that the mentally deficient has some conception of right or wrong, he may feel that he does wrong, but he does not possess the aversion which would be characteristic of a normal person. The cause of this disorder lies in the incomplete development of moral ideas. The want of judgment, of will, the weakness of character render the moral personality of the feeble-minded unstable, not resistant and thus they become an easy prey of their passions.

The majority of the symptoms referable to the deviations in the moral sphere gravitate around the ego of the mentally deficient. Thus the ego becomes extravagantly accentuated. The mentally deficient individuals have no other thoughts but of themselves. Nothing moves them, nothing disturbs them, except their own disturbances, which they immeasurably amplify. Such a psychic orientation naturally leads to a dominating attitude and intolerance. Envy or jealousy is another derivation of egotism. Jealousy creates defiance and doubt; anger and hatred are the next consequence of jealousy. The mentally deficient may develop a hatred towards the dearest and the nearest. As egotism is the predominating characteristic, there is absence of altruistic sentiments.

Among other typical features of mentally deficient individuals may be mentioned impulsive phenomena. They are spontaneous and involuntary psychic manifestations. Normally our acts are controlled by two factors—desire or an impulse for action on one hand and reasoning on the other. The latter controls and inhibits the former. When the intellect is impaired or defective, the impulse predominates and the desired act is executed no matter how deleterious it may be; in such cases we observe frequently sudden impulsive acts in which neither reasoning nor will-power intervene. In some cases the mentally deficient may yet attempt to reflect upon his premeditated act, he may yet appreciate the immorality and criminality of an illegal act, but the appreciation and meditation are not profound enough to overcome the instinctive tendency and

the person succumbs to the latter. Morbid impulses may be manifest not only in criminal acts of a gross nature, but also in minor acts. The tendency to excesses is commonly observed in these cases.

In mental defectives, besides a certain degree of intellectual inferiority, there is particularly an inherent deficiency of inhibitory power. The whole life of mental defectives is composed of incidents of an instinctive nature, as the instinct predominates in them, and, therefore, their actions are invariably the result of mental activities. The impulses are no more under control of the cerebral centers, which ordinarily regulate our actions; but they exercise their influence on the motor sphere by producing an excessive activity. In such cases naturally there can be no choice of action, each movement is the immediate result of sentiment. The acts are unconscious, they must be executed, because they are out of the field of struggle, which normally exists between reasoning and passion. The acts are, therefore, mechanical, automatic, and of a reflex nature. Besides the mental defectives there is another class of individuals with abnormal mentality. Although they could not be considered as defective and not as insane in the strict sense of the word, they are, nevertheless, different from normal persons by their power of reasoning, by their sentiments, tastes, sympathies, etc. To this class belong the large category of psychopathic individuals.

Under the term of psychopathy is understood a pathological state of an individual, whose psychophysical resistance is constitutionally diminished; in other words, it is a condition which is a deviation from the normal type of humanity. In such a person there is an interruption of harmonious equilibrium existing between various functions of cerebrospinal centers; the co-operation and adaptation of these centers are incomplete. There is an ataxia of thought, of sentiment, of will, of psychomotor functions. According to the elements involved, these patients form several groups, which are only apparently different from each other, but under which is hidden the same individuality.

The most important characteristic features in psychopathic persons are found in their psychical sphere. The develop-

ment of their intellectual faculties is not defective, but irregular and there is a want of equilibrium in these faculties. Such patients are only partial, incomplete beings. They may have a remarkable memory, but they cannot fix their attention. Their mental instability is sometimes extreme. At the same time they may be eccentric, dreamers, with romantic tendencies. They are emotional, timid, haughty and may be affected with moral perversity of the gravest nature. The best illustration of the loss of psychical equilibrium is found in the psycho-neurotic phenomena, which develop with the greatest facility in psychopathic persons. Among them obsessions and morbid impulses are the most striking.

What is an obsession? Normally an idea, a sentence, an image may unexpectedly invade our mind and obstinately persist. It is sufficient, then, to exercise our will to a certain extent and make this phenomenon disappear. This, so to speak, physiological obsession, never leads to a morbid impulse. When a morbid obsession occurs, the cerebral centers are involved by a certain image or idea, which remains fixed and suppresses subsequently all antagonistic images or ideas. This is accomplished not without a struggle, but the tenacious idea is accompanied by a moral pain so intense that it subordinates the will, and the individual, perfectly conscious of what is going on, but powerless, finds himself irresistibly forced toward acts of which he himself disapproves. The obsession leads to an impulse, and these two phenomena are in the same relationship, as a thought to the act. The following two examples will suffice to illustrate the psychic status of this category of mental abnormalities.

A young woman of thirty-five, who was profoundly psychopathic, whose heredity was the most unfavorable (father syphilitic, mother alcoholic, a grandfather had paresis), had several miscarriages accompanied by tremendous losses of blood. Her recovery was of long duration. Soon there developed morbid impulses. Being a butcher's wife, she assisted him in carving meat in the shop. On several occasions, while handling the large knife, she felt a desire to cut off the customer's head. She realized her condition, she struggled with herself, resisting the torturing

temptation. Finally, once, in the presence of several customers, she began to scream; the knife fell out of her hand; trembling she begged them to remove the knife from her sight, as otherwise she would commit murder. A young pharmacist, who has been under my care for the last two years, has frequently the almost irresistible desire to commit suicide. He is fully conscious of his condition, fights it often at the expense of his sleep. Once riding on a boat he felt the necessity of jumping overboard. Fearing for himself he begged the passengers to tie him to a post and keep him in this position until the boat landed.

Obsessions and irresistible impulses may affect also crimes of a less important order. In kleptomania there is an irresistible impulse to possess objects which are of no value. This is frequently done by those who are otherwise perfectly honorable, who possess sufficient means. Here, they are perfectly conscious of the criminality of the act, and of the consequences to which it may lead. They struggle against this tendency, they suffer morally, but they finally succumb to the irresistible impulse. Arson, assault, rape, all varieties of sexual perversion, may be committed by a psychopathic individual under the influence of an obsession.

What is the outlook in obsession with irresistible impulses? The evolution of these symptoms presents nothing typical. It may be periodical and intermittent. Sometimes it appears for a short period and disappears completely. In other cases it is slow, remains stationary for months and years. In still another series of cases the symptoms disappear, but recurs from the least cause. As Magnan has well said, "They are incorporated in the mental state of the individual, and never become separated from him. Appearing now and then during his life, they never undergo modifications; they are always the same."

On the basis of our conception of the subconscious world the phenomena under discussion finds no adequate explanation. The role of pathogenetic forces in the causation of psychoneurotic manifestations by the psychoanalytic school is pretty well established. As the aim of this contribution is not the psychological aspect of the psychoneuroses but their sociological value, the analysis of the

mental processes and of the conflict between the conscious and subconscious ideas which leads to the formation of obsessions and impulsive tendencies and other mental disorders characteristic of psychoneurosis, will be omitted.

On the foregoing pages we have discussed psychopathic individuals whose chief characteristic is a strong susceptibility to abnormal mental phenomena. The latter may be not only of the psychoneurotic variety, such as obsessions, anxiety, etc., but also of genuine psychotic type. Such individuals are perpetual candidates (figuratively speaking) for manifestations of a strongly pathological character and under the influence of potent factors may cross the border line and develop genuine Psychoses.

It is not the aim of this address to enter into a full discussion of the very large domain of mental affections, but the intention is to indicate hastily in a few general lines the fundamental disorders which characterize insanities. Our chief object is to lay emphasis on the grave problem of prevention of mental abnormalities of all kinds and to present a general outline of eugenic endeavor.

Psychoses are characterized essentially by disturbances in ideation, in perception, in affectivity, in personality, in consciousness and finally in activity. The extent to which each of these elements is involved, the implication of some and the integrity of others, the interrelation between them, the influence of one of them upon the other, are all factors in the formation of the great variety of Psychoses. It is not my desire to discuss them from the academic standpoint, as such an attempt will serve no purpose at present. Since my sole intention is to lay strong emphasis on prevention of mental disorders, their Etiology deserves mentioning. The following causative factors should be borne in mind. Predisposing causes (general and individual) exciting causes (psychic, physiological and pathological.) The general predisposing causes are: Political events, revolutions, war, religious ideas. The individual predisposing causes are: Heredity, age, sex, occupation. The exciting causes are: Excesses, emotions, depression, passion, seclusion, puberty, menstruation, pregnancy, puerperal state, lactation, menopause. Finally among the pathological causes one may mention: Intoxications,

infections, nervous diseases or visceral diseases, operations.

With these preliminary remarks let us approach the subject of prevention. Whether we deal with mental deficiency or psycho-neuroses or else with psychoses, there is one particular causative element among those mentioned above that stands out prominently, viz. heredity. Statistical and experimental studies, as well as careful clinical observation, prove this irrefutable axiom that an individual invariably bears evidences of tendencies acquired through the germ-plasm of his parents. The character of predisposition is determined by the presence in the spermatic or ovarian cells of concrete hereditary factors which determine the hereditary transmission. Heredity is the cause of the causes. In a study made several years ago especially from the standpoint of etiological incidents (Proceedings of the American Medico-Psychological Association, April 1916) the writer was able to arrive at the conclusion that in the outbreak of mental disorders in the form of Psychoneuroses of Psychoses, etiological incidents of an emotional character immediately preceding them play a conspicuous role since they have a powerful influence on the affectivity and through the latter on the formation of ideational complexes. Mental disorders occur in consequence of factors which are capable to influence the feeling-tone of persons whose mentality is potentially unstable by reason of a hereditary morbid predisposition. In such instances the exciting element may not necessarily be of a strong character. Even slight emotional occurrences may be the point of departure of psychotic manifestations in a hereditary predisposed individual. In the above mentioned study one finds etiological factors of an affective character. Affectivity is the fundamental basis of the personality. It controls our actions, and as Bleuler says, we act only under the influence of pain of pleasure and affects produced by them maneuver our logical reflections. A. Godfernaux in his book, "Le sentiment et pensee" justly remarks that logic of sentiment conforms more to the deep necessities of existences than cold and rational laws of association of ideas; the affective state is the dominating force, the ideas are only its subjects. Young goes still further by saying that the strongest ideas that have the firmest hold on the personally may be

totally inhibited by the affects, and the stronger the affect, the more promptly disturbances will be created in thought and action.

Among the emotional incidents playing a stimulating role in the development of psychotic phenomena the following may be mentioned: Disappointments of various sorts occurring against all expectations, sudden state of anxiety from any source, sudden fright, loss of fortune or of ordinary means of livelihood, sight of mutilated beings, seances of hypnotism or of spiritualism, adverse results, unemployment, privation.

On the preceding pages other exciting factors have been mentioned besides the psychical ones. Physiological as well as pathological causes may commence a mental disorder but most frequently in individual hereditarily predisposed. Persons of a pathological make-up are inevitably prepared to develop psychic disorders at any period of their life: the soil is there, it is only waiting for an exciting cause such as were mentioned above. Herein lies the problem of prevention of psychic collapse.

In considering the subject of prevention, it is well to bear in mind not only the above described etiological factors, but also some important exogenous causative elements. Mental disturbances may follow infections and intoxications. Syphilis plays a very important role. If we consider its effects on the central nervous system with the result of a very large number of cases of Tabes, Paresis, Specific headaches, Specific palsies of central of peripheral nature, even as far as the third and fourth generation; if we further bear in mind that Syphilis may produce various mental phenomena simulating the classical psychoses, (see psychoses other than paresis in syphilitics, Journal of American Medical Association, October, 1917,) we will be in possession of facts which belong to the preventable category. Tuberculosis is another affection which through its toxi-infections elements exercise a profound influence on the intellectual spheres. It belongs to the preventable class of affections. Alcohol and Narcotics produce a deleterious effects on the nervous system and on the intellectual processes. They lead to a progressive mental degeneration, especially in individuals sprung from a neurotic stock. Literature is abundant with examples of this character, (See

Journal of American Medical Association, 1907 and Dominion Journal, 1909.) it is therefore evident on what lines our preventive activity is to be carried out.

On the first pages of the present study, particular emphasis was laid on the chief characteristics of mental deficiency. It was pointed out that there is an inherent intellectual inferiority combined with an inherent deficiency of inhibitory power, that the whole life of mental defectives is composed of incidents of an instinctive nature, that their personality is characterized by an incapacity of being influenced, by lack of discretion, by strong criminal propensities, life-long intability, unsociableness, exaggerated self-esteem, vanity, egotism, complete want of ethical or altruistic ideas and impulses, unconsciousness of justice and morality, that the ethical shortcomings render them useless as members of society.

If one considers the facts that according to the latest statistical investigations only 5% may prove capable of earning the minimum of maintenance, that a great many after several attempts of becoming wage earners fall back into the class of unemployed, and that mental defectives require life-long control, that such control must be provided by the community, if all these facts are seriously considered, one must admit that the mental deficiency problem is one of the gravest and most difficult social problems. Prevention is the most fundamental solution of the difficulties and it should commence first of all with the consideration of the data supplied by the problem of heredity which has a great deal to do with the development of these defects. Prevention of marriage of individuals whose family histories reveal the presence of psychotic disorders and whose personal histories reveal the existence of diseases of a degenerative character, such as Lues, Alcoholism, etc. (see above) is indicated, sterilization of mental defectives is the other important measure in our endeavors of combating propagation of unsocial or undesirable species.

From the foregoing remarks we are thus gradually led to the consideration of the principles of Eugenics. As the name implies, eugenics means regulation of reproduction of a superior race based fundamentally on the principles of heredity. This can be accomplished by a proper

mating of parents who, scientifically investigated, present no conspicuous anatomical or physiological defects. The second eugenical measure in our efforts to preserve a more or less normal community is to interfere with the propagation of the mentally unfit.

That the role played by heredity is enormous, all are agreed. It is, therefore, urgent to direct our energies to the prenuptial conditions. Legislation in that direction is essential, but in order to obtain laws which require profound changes in old time customs, it is necessary to alter public opinion. The latter can be accomplished by making the public understand the laws of heredity and the fundamental principles that since the home constitutes an essential element of the foundation upon which our social structure has been built, it is important that the elements of the community called "home" possess healthy and normal characteristics. To disseminate this knowledge in the interest of eugenics among the masses it is advisable to address oneself not only to the nature, but also and particularly to the youth during the school age in order that the latter be qualified to apply this special knowledge to the subject of marriage which is of course characteristic of early life. Diffusion of specific knowledge is essential to the progress of eugenics.

The problem of race betterment embraces the two fundamental elements of eugenics, namely the knowledge of the laws of heredity and sterilization of the mentally unfit. The beneficent results of education in that direction are too obvious to dwell upon. Such an enlightenment constitutes the chief if not the only resource upon which dependence may be placed for progress in eugenics. The question naturally arises, how and by whom should this education be carried out? These practical questions are of a sociologic dimensions. They require special elaboration and in extensive dimensions.

The object of this address was merely to make a few comments and to call attention to a problem which is extremely vast in its practical applications. To present it in all its ramifications will require a separate volume. I have endeavored to present the subject of mental abnormalities from a practical standpoint. I suc-

ceeded only to give an outline of mental deficiency, of psychoneuroses and of psychoses. My object was solely to emphasize the relationship of the subject to the problem of applied eugenics. Many features of it have not been dilated upon sufficiently for want of time and space.

Many a page could be written on mental hygiene which is a derivative of eugenics. A great deal for example, could be said of the so-called "nervous child." The latter may not be mentally defective, nor insane and still present peculiarities of disposition, of temperament, of the mode of thinking, and feeling, all of which denote a special make-up which under influence of a more or less great stress later in life especially at the age of puberty is likely to undergo a psychic collapse. Here is a great task for the hygienist to undertake, namely, how to proceed in order to bring about the proper development of such a nervous subject from infancy to manhood or womanhood. The hygienists' task is to consider the child's development in infancy, in second childhood, during puberty, during adolescence, — otherwise speaking at different periods of life each with its special physiological requirements. The future member of the community is the product of proper or improper, of normal or abnormal orientation and utilization of those peculiarities which constitute, "the nervous child." Eugenics, mental hygiene are based upon profound knowledge of physical and psychological forces which control biological units. Recognition in childhood of characteristics which point to mental disorders in the future, the establishment of mental clinics for their early recognition and therefore for efforts in prevention, finally the practical application of such a research to the management of delinquency which is intimately connected with and is frequently a direct corollary of mental disorders,—are all problems within the scope of our thesis. If we consider the fact that at the end of the year 1919, there were in this country approximately 250,000 patients for mental diseases cared for during that year at a cost of \$50,000,000, that in the same year one death in 22 of the whole adult population in the State of New York occurred in a hospital for the insane; if we consider the fact that there are in the United States at least 500,000 mentally

deficient, that each year in this country alone about 500,000 mentally disordered, mentally deficient, or unstable, pass through courts into correctional institutions, if we acknowledge all these facts, the magnitude of the problem is certainly striking. The entire subject in all its ramifications is extremely vast and too extensive for one discourse.

DISCUSSION.

Dr. Walt P. Conaway, Atlantic City.—I have enjoyed Dr. Gordon's remarks very much, and since my experience with such cases, as we have seen today, has been very limited, I thought I might add to your program a few remarks concerning that great number of unfortunates who are semi-insane and, therefore, semi-responsible. In a recent edition of Grasset's book, "The Semi-Insane and the Semi-Responsible," as translated by Dr. Smith Ely Jelliffe, of New York, some very excellent classifications of delusional ideas have been suggested. Regis adopts the six following groups: 1. Ideas of satisfaction, grandeur, richness and invention; 2. Ideas of humility, despair, incapacity, ruin, indignity and autointoxication; 3. Hypochondriacal ideas of negation and of bodily deformity and heinous crime; 4. Ideas of persecution, jealousy and defense; 5. Religious or mystic ideas; 6. Erotic ideas. These various forms of delusional ideas may be met with in the semi-insane, with the constant characteristic of their not being very profound, or, chiefly, of being limited. In reviewing the literature, I was very much surprised to note the great number of men who have achieved wonderful success in literature, music and art whose mental condition classed them, at least, among the semi-insane or demifous, as Grasset calls them.

"One of the remarkable achievements of **Shakespeare** is that he has created with the wholly insane, such as King Lear, types of people who are less afflicted," and has described the demifous or the semi-insane. Thus, Lady Macbeth is seized with a "hysterical obsession with nocturnal somnambulism," and "here," adds Regis, "we must recognize the fact that **Shakespeare** was far in advance of his time." Hamlet is a "young man, who, having in his early youth had his ideals and his dearest affections blasted, and who, while he is able to avenge his father, falls into an insimulating madness in order more surely to curable neurasthenia. Hamlet is, in reality, a pessimistic neuropath, under the guise of an apparent madman." **Ibsen**, with less medical precision, has depicted in his plays, not the wholly insane, but the "semi-insane, the abnormal, the neuropathic, the eccentric, the unbalance, the obsessed, the impulsive, etc." In his excellent study of the Russian novelists of the nineteenth century, Ossip Lourie has shown that "no literature offers so many cases of pathology of the will as Russian literature." He quotes this phrase of the psychiatrist **Orchansky**: "It is only the smaller number of the insane who are in hospitals in Russia. On the other hand, an

enormous number, more than 100,000, of such mental invalids live at large." It is the semi-insane living in freedom outside of asylums that the Russian novelists study and depict. In the works of Tolstoy, "we find a homicidal degenerate in the 'Kreutzer Sonata,' and raving alcoholics in 'The Dominion of Darkness..'"

Charles V. was the son of an insane man and a grandson of an epileptic. Darwin appears to have suffered from serious neurasthenia. Schuman had dementia praecox and died at forty-six years of age in an asylum of Dr. Richards, near Baun. An autopsy showed cranial osteophytes, thickening of the meninges and atrophy of the convolutions. Chapin, during his whole life, suffered from excessive nervousness, which grew much worse at times, and life was seldom pleasant. He died at the age of thirty-nine, and of tuberculosis. Max Nordau says "that Richard Wagner is accused of having a greater degeneracy than all the degenerates that we have thus far seen put together. The stigmata which are found in him are most complete and richly developed. He presents in his general mental constitution persecutory delusions, ideas of grandeur and mysticism; in his instincts a vague philanthropy, anarchism and a spirit of revolt and contradiction; in his writings are found all the characteristics of graphomania, i. e., of incoherence, flight of ideas and a tendency toward silly puns, with, as a fundamental element of his nature, a characteristics emotionalism that is both erotic and religious."

Mozart is the type of precocious mind. He played at harp at three years, composed concerts at five and undertook a concert tour at six. He was extremely nervous and had many peculiarities. Beethoven became deaf at thirty. Rossini's psychic disturbances have recently been brought to notice by the *Chronique Medicale*, which has called attention to the study of Filippi (1892). Rossini suffered from severe neurasthenic attacks from his fifty-fifth year. In 1850 he had shown some very apparent psychic and cerebral disturbances, which grew worse until 1852. He became depressed and often was taken with fits of weeping, attacks of despair and impulsions to suicide. He complained chiefly of an intolerable sense of coldness in his hands and of lack of sleep. ". . . I feel all the miseries if a woman," said he, in 1854, "the only thing that I lack is a uterus." He tried magnetism without success and returned to Paris in 1855 for hydrotherapy. In nineteen years, Rossini had written thirty-six operas; he suddenly ceased to write at the age of thirty-eight, after having written "William Tell." Diderot had already said: "Oh, how near genius lies to insanity! Those whom heaven has marked for either good or ill are subject more or less to those symptoms. They have them more or less frequently, more or less violently. They are shut up or put in chains, or else they have statues erected to their memory." And elsewhere: "Men of pensive and melancholic temperament need but the slightest derangement of their minds to show that extraordinary and almost divine perception, which flashes out at intervals and

which culminates in ideas which are sometimes sublime and sometimes insane."

Scientifically, one thing only is demonstrated: That is, the frequent coexistence of intellectual superiority and a neurosis in the same individual. Furthermore, the psychic centers are essentially multiple and complex; they do not form in any person a homogeneous whole of which the parts are all uniformly developed. It can be understood how, in the same person, certain centers may develop exuberantly, while others suffer and become diseased.

The common trunk, which unites superiority and neuroses, is a temperament, but is not a disease. Medically, therefore, genius and superiority are by no means to be considered as diseases to be treated and cured. The superior keeps his high social standing, which he must protect and develop; he is not necessarily ill, and if he be so it is not by reason of his superiority, but because of a coexisting neurosis, which, it is admissible to advise upon and treat, to take measures against it, and, if possible, to cure. In rejecting the superior individual in a group of healthy people one does not, as a result, thrust him into the mediocre class. By lopping off a diseased branch, healthy branches grow all the more vigorously. It would have been wholly ridiculous to have wished to cure Pascal of his genius, which was not a disease; but if he could have been cured of his neurosis, his genius would have lost nothing by it, but quite the contrary. If it had been possible to prevent or cure the madness of Guy de Maupassant, the number of his masterpieces would certainly have been increased. **Genius is not a neurosis; but a neurosis is more often the penalty of genius.** Intellectual superiority, therefore, is not a symptom of neurosis. The neurosis is rather the scar or accident of superiority. It is not cause, it is the obstacle.

I will end with these conclusions, which seem naturally to follow from the preceding development: 1. Many intellectual superiors have more or less marked psychic defects; 2. Many have psychoneuroses. Therefore, certain of the semi-insane have a high social value which distinguishes them absolutely from the insane; 3. Psychoneuroses and intellectual superiority, when they coexist in the same individual, are not consequently the same or dependent the one upon another. This particular question may be modified from one year to another by the constant progress of science, but the essential basis of our study remains intact and we can lay down the following general conclusions:

1. Between the block of sane, responsible people and the block of irresponsible insane there is a group of semi-insane, with limited responsibility.

2. These semi-insane are daily in the eye of the general public and under lay observation; they have also invaded the drama and the literature of all countries.

3. These semi-insane have definite clinical characteristics which enable us to say that their existence is scientifically proved.

4. These semi-insane may have great social influence, as has been proved by the number of superior intellectuals who have shown the stigmata of semi-insanity.

5. These semi-insane may also be, and often are, harmful to society, whose duty and also right it is to protect itself against their misdeeds, while at the same time helping them and treating them.

THE INTEREST OF THE MEDICAL PROFESSION IN PUBLIC SCHOOL HYGIENE.

By **Harry W. Haight, M. D.,**

Highland Park, N. J.

A few days ago your brother practitioner was summoned over the telephone by an agonized and excited voice: "Doctor! doctor! Won't you please come quick! My little boy has fallen from a chair and is bleeding terribly from a cut on his head. Oh! doctor, hurry! Please! What shall I do! Do you think my little boy will die?"

Of course the apprehensive mother was told to press on the bleeding spot, with a clean handkerchief, if it really were bleeding badly, and to let the cut alone, if the blood were clotting of its own accord. The wound turned out to be nothing of consequence. The bleeding had stopped by the time the doctor arrived. A stitch of two, inserted with novocain, painlessly, to the great joy of the mother, took care of that, but the shock and agony of apprehension on the part of this gentle, little lady, for she proved to be a gentle, refined, educated and cultured lady, was manifest for a day or two. What was wrong here?

Subsequently the doctor asked the lady if she had ever had any training in hygiene and first aid in school or out of it. The inquiry showed that she was totally unprepared to face any sort of medical emergency or experience. How many such do we find? One contrasts the resultant apprehension to the thousands of cases where a layman has dealt calmly and wisely with an emergency; upon careful inquiry one finds that in almost every instance where the layman did well he had some sort of previous preparation. Usually he had learned from a similar case, a course at the Red Cross, or other connected instruction. In daily practice not only do numerous cases occur where preparation is needed to prevent apprehension or genuine damage in case of accident or disease, but as the practitioner makes his rounds he sees many dirty, poorly kept dwelling places; and many instances of bad habits and bad ways of living come to his

attention. How often do cases of tuberculosis of bone or lung, cancer, clubfoot, mastoid, eye strain and other common complaints show up at the office, weeks, months, or even years too late? How often do we encounter preventable complications of the ordinary contagious and infectious diseases, where the primary disease was lightly regarded by the untutored layman? How often has every practitioner wished for a free laboratory service and a free x-ray service, where he might send the doubtful cases without consideration of expense to the patient or of the acceptance of charity, and yet, how many communities have a citizenry educated to the point where they would provide a public health service developed to that degree?

Perhaps one would be justified in summarizing the needs for instruction in hygiene, as follows: 1, First Aid and accident prevention; 2, Habit hygiene; 3, Home hygiene; 4, Community hygiene; 5, Dealing with common diseases.

To a practitioner viewing this table of interests it may seem that save for particulars in individual cases these matters are somewhat out of his line of work. That may be. Nevertheless, does not every practitioner have a material interest in these matters? Does not the attitude and co-operation of one's clientele depend largely upon previous preparation? Will not a group of people who have been well taught in the above subjects have a better insight into the benefits ensuing from the efforts of their doctor? Will they not, therefore, be more willing to patronize and to pay?

Taking another point of view, the practitioner might say: "Yes, but these are matters of education or teaching. The place where teaching is done is in the schools, and if you wish to reach large numbers, in the elementary schools. I am not a teacher. These are matters for teachers or educators." To be sure they are. But in view of the facts; that the medical profession is the class most active in matters of health; that the medical profession is the trustee of the body of knowledge and experience which has been accumulated concerning these matters, and that the medical profession has a material interest involved, would it not be better for the laity if the medical profession had a voice in shaping the policies which underlie the activities of the public schools in these affairs?

What is the present status of hygiene in the public schools of New Jersey?

The State of New Jersey has a hygiene law. That law requires that hygiene be taught in every school of elementary grade approximately twenty school hours per year. Not only is the hygiene law not enforced, but in issuing a pamphlet called "The Making of School Programs," a former State commissioner of education, whose duty it was to enforce the hygiene law, suggested that the subject be taught during the period for the opening exercises, when there was likelihood that the time would be devoted to other purposes and actually prescribed a number of hours considerably less than the number required by the statute. Not only does this circumstance give hygiene a low place in the public school curriculum, but State examinations are held annually in such subjects as arithmetic, geography and history. None is held in hygiene.

It would seem wise and fair that a relatively new subject of this importance be encouraged in every way. One can only query: "Is it?" The impressions gained from physicians generally and from one physician in particular, who had visited over 100 public schools in New Jersey in quest of knowledge concerning their hygiene courses, are to the effect that in most places the instruction in hygiene is very inadequate, a farce, or lacking altogether. From these impressions it would be unfair to infer that the State Department of Education had devoted no effort to the entire subject of hygiene. Two syllabi have been issued and in some places considerable effort is devoted to the teaching of hygiene and inspection for good habits. A State department of physical education has been created and is functioning. Medical inspection or examination and visiting nurses have been secured for many schools. Much very good work has been done along those lines, but as to the teaching of hygiene, the most basic and essential thing, the very thing one might think educators would be most interested in, one would hardly claim that it has been at all adequately done.

What, then, is to be done about it? Would it be wise to attempt to force the teaching of hygiene by act of the State Legislature? The hygiene law referred

to was an off-shoot of the so-called prohibition law, which required that certain time be devoted to the teaching of the evil effects of alcohol. It did arouse antagonism. Might it not be better to try persuasion first? Under the existing laws and customs the State commissioner of education can either suggest or make compulsory a uniform, State-wide course in hygiene. Should not the medical profession unite in the following requests of the State commissioner of education?

1. That the subject of hygiene be given a place on a parity with other essential elementary school subjects in all State educational activities.

2. That an adequate course and procedure covering the subjects of First Aid, Habit Hygiene, Home Hygiene, Community Hygiene and Dealing With Common Diseases be prescribed for all institutions of learning of all grades in New Jersey and be put into effect by appropriate measures.

3. That the State commissioner of education consult the proper representatives of the State Medical Society in devising this program and putting it into effect.

Postscript—The present State commissioner of education, the Honorable John Enright, has welcomed the above suggestions and requests. He has promised to give the medical profession the recognition requested and to take steps to revise the present course in hygiene shortly. He has also promised to have State examinations in the subject of hygiene.

ADDRESS OF THE RETIRING PRESIDENT OF THE MORRIS COUNTY MEDICAL SOCIETY

Delivered at the Annual Meeting, September
12, 1922.

William F. Costello, M. D.

Dover, N. J.

This meeting being devoted annually to a consideration of the business affairs of the society it seems proper that we should follow the example of our business friends and take a survey or inventory of our organization; that we consider the worth of our society; what it is paying us in the way of dividends; how it is discharging its obligations to the profession and to the community; and, finally, and not the least important,

what we, as individuals, are contributing to aid the society in the accomplishment of its work and the attainment of its purposes.

We have heard, in the past few years, a great deal of the problems of reconstruction. Our commercial, industrial and social life has been influenced thereby; and all unite in placing the cause on the recent World War. It is not surprising that in this period of unrest, matters pertaining to the field of medicine should also be involved; but we cannot place the blame entirely on the war. It may have precipitated certain changes, but its attitude of reserve and its apparent indifference to certain danger signals, sounded by some of its members, is where the real cause is to be found.

Just as a proper organization is necessary for the successful conduct of a business enterprise, so is the proper organization of our society necessary. Just as a proper functioning of this organization in business is essential to success, so is a proper functioning of our organization essential, and no organization can function to its full capacity unless each of its component parts does its full share of the work.

The value of this organization has been nowhere better demonstrated than in the accomplishments of our Welfare Committee. We are all aware of the birth, in the past few years, of several different cults whose members have set themselves up as practitioners of the healing art. The dispensers of diplomas to these various cults accepted students, with no consideration of their previous education, and with no concern as to their moral fitness. Almost overnight your butcher boy was converted into a chiropractor and, aided by an advertising agency, conducted by its alma mater, he launched out to prey upon the public. Our own State of New Jersey, through its Assembly and Senate and, I am ashamed to admit, aided by the vote of our present senator, Mr. Whitney, recognized them to the extent of granting them the privilege of treating any condition presenting itself, either pathological or normal. By this act the standard of educational requirements, built up by years of constructive work by the State Department of Education, was crushed.

We, ourselves, were partly at fault.

While the representatives of these cults were engaged in a campaign of publicity we stood still. We assumed that the prestige and dignity of the profession were so highly regarded by our legislators that they would repudiate such a measure. The reception accorded your representatives when they went to Trenton to explain the attitude of this medical society to our legislators showed us how much regard they had for our prestige, our dignity and our opinions. Here was the real birth of the Welfare Committee. It had had indifferent support before, but the shock and indignation produced by the passage of such legislation and by its method of passage, brought the rank and file to a realization of the fact that an aggressive campaign, previously urged by the committee, was necessary to produce results. The success of their efforts proves the wisdom of that decision. There has been no piece of public health legislation enacted since that time, which has been inimical to the interest of the general public.

The activities of this committee have not been limited to legislative matters. Adjustment of differences between the profession and the Compensation Commission have been effected. Through their efforts the medical and hospital fees will exceed the \$50 allowance, the commission can, on certification by the physician, increase that allowance to a maximum of \$200. Several bills relating to the control of venereal diseases, laws relating to child labor and, in fact, matters pertaining to every phase of public health legislation, have had attention. In all their work at Trenton your committee has never had the assistance, encouragement or support of an assemblyman or senator from Morris county. The dignified, yet forceful, methods adopted by this committee have demonstrated to the profession and to the public that medical men can interest themselves in legislative matters with no loss of prestige or dignity, and today the voice of the State Medical Society is a potent factor in the consideration of public health legislation.

Beside contributing to the success of this undertaking your county committee provides legal defence for members in good standing, in the event of suit for malpractice. Membership entitles us to The Journal of the State Society. At its

meetings papers treating of topics of scientific interest to the members are read and discussed. These meetings afford an opportunity for the members to fraternize one with another, resulting in an adjustment of any petty differences which may exist and in developing a spirit of good fellowship. These are a few of the things that our county society is doing for us. Let us ask ourselves: What are we members doing for our society. To finance any activity requires money. Our society is no exception. Eight of the twelve dollars paid annually by us goes to the State Society. If this eight dollars is not paid in advance the particular member in arrears loses his membership and the benefits incident to it. The per capita tax of every member has been paid by this society, but eighteen members have failed to pay their dues to date; the total amount outstanding being \$477. Carelessness, forgetfulness and indifference have been advanced as reasons, but not any of them can be accepted as an excuse.

During the past year we have been favored by the presentation of the best series of papers that it has been the privilege of this society to hear. The attendance at the meetings and the discussions elicited were not what the excellency of the programs merited. A few years ago this society celebrated the 100th anniversary of its birth. The large attendance, the enthusiasm of the members and the general spirit prevailing at that meeting augured well for the future. Judging by the activities of some of the members since that time they apparently have gone on laboring under the impression that anniversary meetings are the only meetings of the society.

Another matter which I feel it my duty to call to your attention is that of lodge practice indulged in by some of our members. Men or women and their families belonging to beneficial organizations are treated for a given amount per capita per year. This is absolutely not in accordance with the principles of ethics governing this society, and ought not to be tolerated. If a member values the few dollars received for this type of work more than he does his standing among his fellow practitioners, then I feel that the privilege of membership should be withdrawn. It is scab pay and is bound to be scab work.

It has been my privilege to have been in fairly close touch with many of the activities of this society and to have had the opportunity to discuss these problems with men throughout the State engaged in the work with your Welfare Committee, and it is my feeling that if we, as members of the medical profession, have not sufficient interest in the affairs of the society to support its activities, to uphold its policies, to pay our dues and attend meetings, and to maintain its prestige by adherence to the recognized code of ethics, we cannot blame the layman for withholding his support from us and being influenced by the propaganda of the various cults of which we have spoken.

That this society, by its activities in the past, has proven its value to the profession and to the community cannot be denied, and I am confident that its value can be greatly enhanced if each member will play his part.

Clinical Reports.

LEUKEMIA; AN ATYPICAL CASE*

By Benjamin Gutmann, M. D.

New Brunswick, N. J.

Leukemia is a disease about which much has been written, and about which there are still many perplexing problems. It is not a new disease, but, since it was first recognized, almost simultaneously, by Hughes, Bennett and Virchow, in 1845, the cause has never been discovered.

The similarity, especially in the acute form, to an infection has many times been noted and is the theory most credited as to the cause, but in spite of much painstaking work, some of which has been done our own Dr. John F. Anderson, no one has been able to correlate these conditions. Circulating malignant tumor and a blood condition resulting from and connected with myeloma are other theories.

Obscure as the etiology of this disease may be the recognition of the usual typical case is comparatively easy, and the purpose of this paper is not a discussion of those types. Since Erlich's classification of the white cells and with

*Read at the meeting of the Middlesex County Medical Society, held October 18, 1922.

the introduction of polychrome stains, much has been learned in the way of differentiation and separation of this disease into varieties and types.

Mention is made in various textbooks of atypical cases, referring more especially to those presenting elements and characteristics of both chief types, and variations in the total number of white cells found in different cases, particularly those with fewer total white cells than usual. The fact that a fair percentage of cases present elements of both types is now quite generally agreed. Also, that the predominance of one type or another, as well as the total numbers of white cells varies with the stage of the disease, is well known.

Within the last few years the term "Leukopenic Leukemia" has arisen. In this condition the total number of white cells may not vary much from the normal, may be either slightly increased or even fewer and yet constitute one of the varieties of the disease under discussion, its recognition depending upon the presence of abnormal or immature cells, or a disproportion between the normal cells, as well as the associated clinical symptoms and physical signs. The term "Aleukemia Leukemia" has also been applied to this variety. These terms, of course, must be considered arbitrary, and so far as I know, have not as yet found general usage.

I desire to report a case which, I think, will fall into this category, and which also had peculiarities which should make it of some interest. At the outset I wish to state that we followed the usual classification and terminology of white cells, as we knew it at that time, being aware that methods have been introduced to differentiate immature or abnormal white cells from normal cells. I refer to the oxydase reaction. It has not been proven, nor is it generally recognized that this is an advantage of over a good polychrome stain for this purpose. The predominating abnormal or immature white cells in the case to be presented is the myelocyte, and in this paper the term will be used to mean those cells of moderate to large-size, containing an irregular, oval or indented nucleus with a moderate to large amount of cytoplasm containing granules.

No attempt was made to differentiate myelocytes and premyelocytes from myelocytes. The identification of these

cells as myelocytes was agreed upon by several men of far greater ability than the speaker in such work, who were consultants.

With the addition of the above-mentioned oxydase reaction there has been added by some a third type of leukemia, namely, monocytic—so called because of the negative reaction with this stain or a large mononuclear cell occurring in abnormally large numbers in cases having other characteristics and manifestations of the disease. While it is possible that this may constitute a distinct variety, it can easily be seen how perplexities are being added in the study of this interesting condition, and the question arises in our minds whether we are not straining at gnats in attempting to so finely separate and classify phenomena in the blood which will eventually prove to be only a syndrome of some common cause.

The patient was a man sixty-three years of age, whose family and past personal history are of no particular importance, except to state that his habits were always good. He was a moderate user of alcoholic beverages and tobacco and denied any venereal infection.

Present illness had an insidious and indefinite onset, and consisted for the most part of a sense of exhaustion and easily induced fatigue, abdominal discomfort of an indefinite nature, except for a fairly fixed pain in the left side in splenic region; nausea after taking food, but no vomiting; eructations, pains in legs, sweats, which he described as "cold sweats," during night or early morning hours, severe headaches and soreness in neck along border of sterno-cleido-mastoid muscles. These symptoms had existed for two or three weeks prior to July 20, 1920, when the patient was first seen and examined.

Physical Examination—The patient was a well-developed and well-nourished man of late middle-age, with an expression of depression on his face. His cheeks were flushed, but color otherwise good. Head, eyes, sclera were clear, pupils reacted equally and normally; ear, patient was slightly deaf, and specialist who treated this condition considered it of catarrhal origin, with no local inflammation in ear itself; mouth, tongue heavily furred by dark-brown coating; teeth, many missing, those re-

maining apparently sound. evidence of recent dental work; throat, showed a chronic pharyngitis, anterior nares normal; neck, along border of sterno-cleido-mastoid muscle there were many palpable nodes of varying size, apparently tender on pressure, which felt like enlarged lymphatic glands. The thyroid was not palpable. There were no abnormal pulsations.

Chest, symmetrical, with equal expansion on both sides; heart, no thrills, apex palpable in fifth interspace in nipple line, with exception of a slight, soft, systolic murmur at apex, the sounds were clear and of good quality, no abnormal accentuations; systolic blood pressures, 158; diastolic, not recorded; lungs, anteriorly resonance and breath sounds, normal; posteriorly there was impaired resonance with diminished breath sounds, and increased tactile fremitus over right lower lobe, suggesting an old thickening of pleura; there were many moist crackles at left base, but no apparent change in resonance.

Abdomen, there was moderate tympanites; the liver reached from upper border of sixth rib to just below costal border; the spleen could just be felt on deep inspiration; area of splenic dullness seemingly increased; no other organs palpable; no shifting dullness in flanks.

Legs showed no edema or varicosities; no enlargement of joints; palpable long bones were smooth; no glandular enlargements other than those mentioned above were felt.

Laboratory Results—Sputum, negative for tubercle bacilli; urine, negative chemically and microscopically, except for a very few pus cells (prostate?); blood Wasserman, negative; blood examination, July 29, 1920, as follows:

Red cells, 4,580,000; hemoglobin, 85%; color index, 1.1; no blasts, poikilocytes or anisocytosis; white cells, 11,100; differential, no cells counted, 200; poly. M. N. 36%; transitional, 1½%; lymphocytes, 24%; large mononuclears, 7½%; eosinophiles, 1%; mast cells, ½%; myelocytes neutrophilic, 29½%.

Progress and Subsequent Course—The patient continued under my immediate care from above date (July 29, 1920) until August 9, when he left this city, for his summer home. During this period his temperature ranged from 97 degrees to 100.7 degrees Fahrenheit, with daily afternoon rise. Pulse, 68-92;

sweats in the early morning hours were of daily occurrence. Complaint about nausea and abdominal discomfort became more persistent. The stools were offensive in odor. Patient slept poorly, but was about house part of day and occasionally took a short auto ride. Exercise of any sort produced great fatigue, and there was occasionally slight dyspnoea. Pains in legs and discomfort in mouth persisted. Diet, rectal irrigations, appropriate medication seemingly made no impression on the gastro-intestinal symptoms.

August 4, Dr. John Musser, of Philadelphia, saw the patient in consultation and agreed with diagnosis. Further blood examinations at this time were in all essential respects similar to above recorded. From August 9 to August 24, the patient was out of my immediate care and under the care of a local physician at his country home. From the nurses' records, which were accurately kept, it appears that the patient grew gradually worse, so that more and more time was spent in bed. The tongue became the seat of actual ulcers, the gums were inflamed, the breath became fetid in odor, headaches were intense and persistent, the glands in neck increased in size and became more painful, the abdominal distress increased, and on one occasion, August 19, he vomited mucous, which contained a fair amount of bright, red blood. At this time a rash appeared on arms and legs, which afterward proved to be subcutaneous hemorrhage. The patient became delirious. The temperature during this period ranged from 97.60 to 102.30, and the pulse from 96 to 132. The temperature remaining elevated most of the time.

August 24, I was called hurriedly to see the patient, with the statement that he was dying, and when I arrived I found him with a pulse that was absolutely irregular and uncountable, dyspnoeic, great difficulty in swallowing, and covered with profuse cold perspiration. Respiration, 32. His body was almost completely covered with large patches, bright red in color, due to subcutaneous hemorrhage. He looked, to all intents and purposes to be in extremis. He responded to very vigorous stimulation (digitalin 1-25 intravenously every three hours, for four doses), and the next day his pulse was 100 to 108; temperature, 100 to 101.2; respiration, 28-32, having

tided over what seemingly was a crisis. Stimulation in lesser doses was continued.

From this period until September 17 the temperature very slowly subsided, and by time mentioned, became practically normal. The pulse remained rather rapid, usually 100-110, and respiration 28-36. The hemorrhagic areas gradually underwent resolution, but the digestive disturbances, ulcers in mouth and headaches persisted. However, the mental symptoms became more and more troublesome. There was mental confusion, muttering often, hallucinations and delusions. These mental symptoms seemed to bear no relation to fever, persisting after temperature became normal.

The glands in neck had decreased considerably in size during this period and there was no change in spleen and liver from that noted in original examination.

September 25, white cell count was as follows: Poly. M. N., 62%; lymphocytes, 28%; large mononuclears, 2% eosinophiles, 4% neutrophilic myelocytes, 3% transitional, 1%.

The mental symptoms persisted and followed no definite trend. The patient was disoriented and frequently rebellious, with halucination and delusions. He was often incontinent of urine and faeces, and at times refused food, so that feeding became a difficult problem. Otherwise, the most annoying symptoms were the stomatitis and gingivitis. Sleeplessness was marked and resisted everything but morphine and hyoscine. The patient still complained of pains in legs, digestive discomfort, and there was considerable foul-smelling flatus from bowel. His physical condition improved, and he was able to spend part of day out of bed.

The persistence of the mental symptoms so long after improvement in his physical condition caused much anxiety, and on October 28 Dr. Dercum, of Philadelphia, was called for conference. His opinion was that it was a psychosis, due entirely to his disease and that the prognosis was that of the disease underlying it. He had seen two other cases of like character.

Blood on Nov. 4th was as follows: Red Cells, 4,200,000; Hemoglobin, 90%; White Cells, 5,9000; Poly. M. N. 57%; Large Lymphocytes, 7%; Small Lymphocytes, 29%; Large Mononuclears,

1%; Transitionals, 3% Eosinophiles, 2%; Neut. Myelocytes, 1%.

It will be seen that change in characteristics of white cells had taken place (this was noted in other examinations not here recorded). There was a marked decrease in the myelocytes and a relative increase in lymphocytes with no marked change in reds.

This relative lymphocytosis is further increased in a count made December 18, 1920, as follows: White cells, 6450; Poly M. N., 51%; small lymphocytes, 39%; large lymphocytes, 4%; transitional, 2%; eosinophiles, 2%; neut. myelocytes, 2. No blasts, poikilocytosis or anisocytosis.

November 9, the patient was able to take an auto ride for first time, although there was no radical change in his mental condition and still required morphine and hyoscine for sleeplessness. His temperature would occasionally reach 99.4 by rectum in evening. December 1, the patient was up and about considerably during day, although he becomes fatigued very easily. Mind has improved, recognizes his surroundings and morphine and hyoscine for sleep could be dispensed with.

December 11, patient was able to take a short walk, and on December 13 went to his office for first time. He was still easily fatigued and complained of aching in legs and soreness in mouth, although ulcers on tongue had completely healed. Improvement continued gradually, and patient, a few months later, considered himself entirely well.

Subsequent blood counts were as follows, January 13, 1921: White cells, 7,800; Poly M. N., 56% small lymphocytes, 26%; large lymphocytes, 9% mast cells, 1%; neut. myelocytes, 7%; eosinophiles, 1%. No blasts, poikilocytosis or anisocytosis. There is a slight increase in myelocytes from previous counts, but the relative lymphocytosis also persists.

May 11, 1921: White cells, 8,700; R. B. C., 4,340,000; Poly M. N., 57%; Hemoglobin, 85%; small lymphocytes, 28%; large lymphocytes, 11%; neut. myelocytes, 3½%.

September 25, 1921: White cells, 5750; Poly M. N., 55%; small lymphocytes, 28%; large lymphocytes, 7%; large mononuclears, 4%; transitional, 4%; neut. myelocytes, 2%. No nucleated reds.

June 15, 1922: Hemoglobin, 90%; R. B. C., 4,850,000; no poikilocytosis; no anisocytosis; W. B. C., 5,600; Poly M. N., 67%; large lymphocytes, 6%; small lymphocytes, 23%; large mononuclears, 0%; transitional, 3%; eosinophiles, 1%; basophiles, 0; myelocytes, 0. No nucleated red cells.

Outstanding Features.—1. A patient with many of the clinical signs and symptoms of an acute leukemia with a high percentage of myelocytes in the beginning of his illness, with only a slight in the total number of white cells.

2. Gradual diminution in number of myelocytes and slight relative lymphocytosis with a return to approximately normal of the total number of white cells.

3. Relatively very slight disturbance of red cells and hemoglobin.

4. Occurrence of what might be termed a crisis, following which there was slow, but steady improvement.

5. A marked psychosis considered to be a consequence of the disease.

6. A complete symptomatic recovery, both mental and physical.

7. Return of blood to normal or nearly normal.

Comment.—Notwithstanding the doubt in the mind of many physicians, the blood finding and clinical picture in this case, in my opinion, justify a diagnosis of leukemia of that type spoken of as leukopenic of leukemia, and if this is accepted, we have a rare instance of recovery from that disease.

The treatment in the main was symptomatic. Large doses of red bone marrow and arsenic were given, but what effect this had, if any, I cannot say.

County Medical Societies' Reports

ATLANTIC COUNTY.

Royal E. Durham, M. D., Reporter.

The regular monthly meeting of the Atlantic County Medical society was held at the Hotel Chalfonte, Atlantic City, on Friday evening, January 12, 1923. Dr. Clarence L. Andrews, our new president, presided and had a most interesting scientific program arranged. Our most attractive program drew many distinguished visitors from neighboring cities. Among these were Dr. Joseph Hunter, Jr., president of the State Society; Dr. Costill, the ex-president of the State Society, and Dr. H. A. Cotton, of the State Hospital at Trenton.

Dr. Joseph Colt Bloodgood, of Baltimore, Md., spoke on "The Diagnosis and Treatment of Lesions of the Pancreas," and Dr. Max Einhorn, of New York city, spoke on the

"Diagnosis and Treatment of Gall Bladder Lesions."

Dr. Bloodgood first called attention to the fact that the pancreas was a deep, concealed, non-palpable organ and that a diagnosis of pancreatic lesions must be made by history and symptoms. In the differential diagnosis, he said, the renal, appendiceal, gall bladder and intestinal colic were all quite distinct and unmistakable and that pain above the diaphragm always excluded kidney lesions. However, in pancreatic lesions the outstanding feature is epigastric colic. The pancreas and gall bladder are very closely associated, but if epigastric colic predominates the picture we have pancreatic disease. Laboratory tests are of little value, and sugar in the urine is an unusual occurrence in pancreatic lesions.

The etiology of pancreatic lesions consists of injury, infection and tumor. The degree of pancreatitis varies from a mild form up to the hemorrhagic type, with hemorrhage, fat necrosis and death. The most important and unusual thing in pancreatitis is the escape of the pancreatic secretions, with a resulting pancreatic peritonitis and trypsin poisoning. If a surgeon ever sees fat necrosis in the abdomen it means a pancreatic lesion. The symptoms of pancreatitis are acute abdominal pain, rigidity of both recti muscles, tenderness, shock, cyanosis and jaundice. Jaundice must be considered in every case, as an acute disease. If the common duct goes through the head of the pancreas we may have marked jaundice, with very little swelling of pancreas. In like manner, if the duct does not go through the head of the pancreas we may have very slight jaundice, with marked swelling of pancreas. In every case of jaundice the feces should be examined for bile. If jaundice does not subside in a comparatively short time, under rest and proper diet and there is no bile in the stools, but bile in the urine, and the Wassermann test is negative, we then have a pancreatitis, and the gall bladder should be drained. If the Wassermann is positive we should, of course, administer salvarsan, for we have a luetic pancreatitis, and this is the only type of pancreatitis in which medicine can be of any use. It is often impossible to recognize carcinoma as the pancreatic lesion in these cases. However, if, after drainage of the gall bladder, the patient recovers permanently we recover after operation points to carcinoma can exclude carcinoma, whereas a failure to of the pancreas.

An abscess or cyst of the pancreas can usually be palpated, and we always find an area of tympany above and between the pancreatic cyst or abscess and the area of liver dullness. In conclusion, Dr. Bloodgood made a plea for early diagnosis and early operation in pancreatic lesions. When we see the picture of acute sharp abdominal pain, which is not relieved by one dose of morphia, tenderness, rigidity of both recti muscles, jaundice, cyanosis and the shock syndrome we have pancreatitis and an early operation is imperative.

Dr. Einhorn spoke on the importance of the direct examination of the bile in gall bladder disease. He said that in gall-stones or gall bladder lesions the bile was very tur-

bid and often the appearance of yellow or greenish pea soup. Microscopically, numerous cholesterin or calcium bilirubin crystals, pus, mucus bacteria and red blood cells were found. Also at times small particles of concretions, consisting of conglomerations of various crystals were found. Very often such findings indicated the probable presence of a stone, which, upon operation, was found to be correct. Whenever a great many cholesterin crystals are found clustered together in the bile, especially of large sizes, it usually presages the presence of calculus.

The bile found in the duodenum contains bile from the liver mixed with some gall bladder bile. Attempts at obtaining pure gall bladder bile have been successful by some investigators. However, Dr. Einhorn considers the view, that the dark bile appearing after the instillation of magnesium sulphate or peptone, is merely gall bladder bile, is not correct, and his opinion is that the changes in color are due to reactions of these substances on the liver, influencing its activity. Dr. Einhorn then reported a most interesting case of duodenal ulcer, combined with gall bladder disease, with a stone in the cystic duct. The ulcer was first treated with doudenal alimentation and then an operation performed, in which a stone was removed from the cystic duct. This case was cited to show how the diagnosis was made from the history and the examination of the bile.

BERGEN COUNTY.

Frederick S. Hallett, M. D. Reporter

The Bergen County Medical Society held its regular monthly meeting at the Union League Club, Hackensack, January 19th. The president, Dr. E. K. Conrad, occupied the chair, with twenty-two members present.

Dr. Samuel Thatcher of Hackensack was made a member by transfer from the Hamilton County Medical Society of Tennessee.

The speaker of the evening, Dr. William H. Dieffenbach, gave a very instructive address, "Advances in X-ray Therapy, with special reference to the High Voltage Homogeneous Rays."

Discussion was opened by Dr. R. E. Knapp, roentgenologist to the Hackensack Hospital.

The meeting ended with refreshments and a social session.

CAPE MAY COUNTY

Eugene Way, M. D., Reporter.

The thirty-ninth annual meeting of the Cape May County Medical Society was held in the auditorium of the Brick Building of the Woodbine Colony for Feeble-Minded Males, Woodbine, November 1, 1922. The meeting was the best attended and most successful from every point of view in the history of the society. The array of talent presented was worthy of a State or national convention and was comprised of men, not only of local eminence, but those of national and international reputation. The list included Professor Alfred Gordon, of Philadelphia; Professor E. R. Johnstone, of Vineland; Dr. Hunter, president of the New Jersey Medical Society; Dr. Conaway, councillor of the Fifth district of the State Society; Dr. Darnell, of Atlantic City; Superintendents Thorn and

Center and Judge Eldredge. The meeting was presided over by the president, Dr. Frank R. Hughes, who introduced Mr. Mulford H. Center, superintendent of the Colony, who gave the following address of welcome:

"Mr. President, Ladies and Gentlemen: It gives me great pleasure to welcome the Cape May County Medical Society and your invited guests here today. When your secretary suggested to me some weeks ago that a meeting of this kind would be both interesting and beneficial to the medical profession and the colony officials, I agreed with him that it would be a splendid thing, and immediately placed the matter before our board of managers for their approval. They were heartily in accord with our plans, for they felt as I did that such a meeting would afford a representative body with whom we wish to sustain cordial and intimate relations an opportunity to see for themselves the problems to be solved with our class of patients. The group of buildings that constitute the colony, not having been built for the purpose for which they are being used, many changes have been necessary, and many others are in the course of progress. Five or possibly ten years may elapse before we reach the degree of perfection for which we are planning, but in the meantime we feel that the institution fills a real need and that everything possible is being done for the care, comfort and safety of our inmates. You are most cordially invited to inspect the colony and observe how our work is being carried on and what has been accomplished. Again let me assure you of the sincerity of our welcome and to express the wish that your visit may be both pleasant and profitable."

The president then introduced George B. Thorn, superintendent of the Vineland home, who, in his usual pleasant and eloquent manner, addressed the society, as follows:

"Mr. President and Members of the Cape May Medical Society: It gives me great pleasure to be here today and to tell you why this institution was established, and what we hope to accomplish. The overcrowded condition of all State institutions, which interfered with the proper classification of 'types' was a dominant factor, and a great demand existed for a State home for idiotic patients, and the idea for its institution was 'hatched' during a conversation with Commissioner Lewis and Professor Johnstone at Manhattan station. The Baron De Hirsh Agricultural School buildings at Woodbine were found to be available and the Department of Institutions and Agencies asked to take them over to be made into a colony. Legislation was enacted and an appropriation of \$75,000 voted and placed at the disposal of a committee composed of Professor E. R. Johnstone, chairman; George B. Thorn, secretary; Mr. Hughes, treasurer, and Barton T. Fell. * * * * *

The president then introduced Professor Alfred Gordon, of Philadelphia, who spoke on "Mental Abnormalities and the Problem of Eugenics." The address was illustrated by five groups of four patients each, selected from the colony. Group 1, idiots with hemiplegia or other paralysis; group 2, idiots without palsies; group 3, idiots with thyroid defects; group 4, racial idiots (Mongolian or

Negro type; group 5, idiots with other physical defects.

Dr. James Hunter, president of the State Medical Society, then addressed the society on some of the problems to be met by the State and medical profession in the care of mental defectives, and said, in part:

"The ever-increasing number of feeble-minded, idiots and insane calls for prompt and intelligent action on the part of the State, the public and the medical profession. There must be co-ordination of action, for the fate of our civilization depends on the organization of all forces tending to the betterment of the human race. The public in general has a false conception of this problem and seems content to leave its solution to the medical profession, but it is not a problem of the medical profession, but of the public, and it is the province of the State to educate the public. Educate them to separate the classes, to provide them homes, clothing, food and care for their physical ills. Special sessions of court should be held for the trial of a feeble-minded and insane criminal, and the opinions of physicians heard in all such cases, and laws should be passed controlling this class, for if left free, the family will grow, therefore, shut off this stream by sterilization. The medical profession has always been and still is willing to volunteer its aid, when necessity requires, but the time has come when the State should realize that the medical profession is worthy of its hire, and cease to look for volunteers. The best of medical service should be procured to care for the mental defective and the insane and paid for by the State."

The meeting then adjourned to the dining-room, where, amidst a beautiful floral display, arranged by Mrs. Center, was served a bounteous repast that met with universal approval. At the close of the dinner, President Hughes called upon Judge Henry H. Eldredge,

Judge Eldridge, in an able address, said: I have always known that there is a direct connection between the law and the Gospel, but never have I realized until today the very important connection between your profession and mine, between the law and medicine. I once heard of a young man who when about to select a profession for himself found considerable difficulty in deciding what line of activity he would follow. He hesitated to study medicine for he did not want to live upon people's ills. He refrained from the law because he did not care to live upon their crimes. Neither did he desire the ministry for then he would live upon their sins. You gentlemen have chosen to live upon people's ills and I upon their crimes, and I have found today that there is a very decided and important connection between them.

(We will give an outline of the discussions and addresses in next month's Journal.—Editor.)

The Board of Censors reported in favor of the election of Drs. G. F. Dandois and H. H. Hornstein as members of the Society and they were elected.

The nominating committee made the following report, which was adopted: President, Colonel Charles M. Gandy; vice-president, Dr. P. C. Washburn; secretary and reporter,

Dr. Eugene Way; treasurer, Dr. H. H. Tomlin; board of censors, one year, Dr. V. M. D. Marcy; two years, Dr. W. C. Haines; three years, Dr. S. D. Mayhew; committee on public health, legislation and welfare, Drs. P. C. Washburn, Julius Way and W. A. Lake; delegate to State Society, Dr. Allen Corson; alternate, Dr. Herschel Pettit.

GLOUCESTER COUNTY.

Henry B. Diverty, M. D., Reporter.

A meeting of the Gloucester County Medical Society was held January 18 at 2 p. m., at the Hotel Paul, when the society was addressed by Dr. A. C. Morgan, of Philadelphia, on "Applied Therapeutics." Dr. Morgan is a specialist and a man of authority and thus his address was listened to with the closest attention throughout its entirety. Following the address, the subject was discussed by the members of the society, who pronounced the subject a most practical and up-to-date one and ably presented.

The society is indebted to the late Dr. Stout for the securing of Dr. Morgan to address the meeting, and he was looking forward to the pleasure of presenting the speaker, but death suddenly called him. Dr. Morgan was physician to Dr. Stout and he described in detail his disability and he stated that he frequently had warned him to be careful and not to over exert himself.

The society named Dr. H. B. Diverty and Dr. Duncan Campbell to prepare resolutions respecting the death of Dr. Harry A. Stout, of Wenonah.

The following resolutions were presented and adopted:

Resolved, We learned with a profound sense of sorrow of the death of our late colleague, Dr. Harry A. Stout, therefor,

Be It Resolved, That we extend to his bereaved family our deepest sympathy in their sorrow.

Further, That we share with the community the realization that in the death of Dr. Harry A. Stout, we have lost a skillful, sympathetic physician and an upright patriotic citizen, a faithful and loyal colleague.

Further, That a copy of these resolutions be sent to the family and published in the local papers.

Drs. Henry B. Diverty and Duncan Campbell, Committee.

The secretary reported that a number of members of the society attended the funeral service of Dr. Stout, while the State Medical Society of New Jersey, of which Dr. Stout has been the corresponding secretary for a number of years, was represented by its president Dr. James Hunter, Jr., of Westville, and Dr. David C. English, of New Brunswick, editor of the Journal of the Medical Society of New Jersey.

Following the business session and the address by Dr. Morgan, the members of the society enjoyed a dinner, served by Mr. Stoerrie.

HUDSON COUNTY.

William Freile, M. D., F. A. C. S., Reporter.

The society met on Jan. 2nd, at the Jersey City Hospital. It was one of the most interesting gatherings of the society. Dr. L. F.

Donohue presided. Some routine business was conducted, including a report of the auditing committee, which certified all accounts balanced, and books in good order, and suggesting that a special form be used in the future, and signed by the secretary.

Dr. Geo. E. McLaughlin gave an illustrated lecture on "The Water We Drink," showing the workings of the Boonton plant, and especially the sterilizing process. He showed that through the efficiency of the process, typhoid fever in Jersey City in recent years has been almost entirely wiped out.

A paper entitled "Tumors of the Breast—Their Clinical Significance" was read by Dr. John F. Erdman, of the New York Post Graduate Hospital. This was afterwards discussed by Drs. Longrigan, Sexsmith, Quigley, Mooney, Faison, Dickinson, Spence and Axford.

Owing to the difficulty in abridging this paper, we shall publish it in full at an early date.

Drs. C. J. Larkey of Bayonne, W. J. Sweeney of West Hoboken, and William L. Yeaton of Hoboken, were designated to arrange for the annual banquet to be held late in February.

Drs. Mortimer H. Linden, J. Feinberg, Vincent J. T. O'Neill and Ralph Brennan were admitted to membership.

MERCER COUNTY.

A. D. Hutchinson, M. D., Reporter.

The Mercer County Medical Society met in regular session on January 10, the president, Dr. Cotton, presiding.

Applications for membership were read and referred to the membership committee, as follows: Carl L. Pierson, M. D., State Hospital, Trenton; Francis S. Chambers, M. D., Trenton.

Dr. John W. Churchman, of the Loomis Laboratory, Cornell University, N. Y., delivered a very instructive lecture, illustrated with slides, on the subject of "Selective Bacteriostatic Power of Aniline Dyes."

The members thoroughly appreciated the address, this line of work, however, being of a most progressive nature in research, the discussion was more or less limited. The latent possibilities surrounding this subject were nevertheless commented upon and fully realized.

PASSAIC COUNTY.

Leon E. DeYoe, M. D., Secretary.

The January meeting of the society was held on the 11th at 9 p. m., President Marsh in the chair. The speaker of the evening was Dr. K. Winfield Ney, of New York, whose subject was "Nerve Injuries; Their Diagnoses and Treatment." He considered the anatomy and physiology of the nerve and, with aid of lantern slides, discussed the processes of degeneration and regeneration, then the pathological changes which take place in a nerve, following its division or trauma of less severity. He said that when operating upon a nerve we must be guided by the results of a careful preoperative physical examination, and not by the gross appearance of the nerve. A nerve may appear to be much distorted or enlarged, but still be able to transmit a nor-

mal impulse. Such an abnormality should only be sectioned if the preoperative examination showed it to be the site of the trouble.

Dr. Ney then showed interesting pictures, illustrating the various steps of a neuraphy; he next described simple tests by means of which a nerve lesion could be located in the arm, even though the arm was encased in plaster down to the hand. In closing, he laid great stress on the importance of preventing over-stretching of the paralyzed part, while the process of regeneration was taking place.

SALEM COUNTY

William H. James, M. D., Reporter.

The regular meeting of the Salem County Medical Society was held at the Memorial Hospital on December 13, 1922, President Thomas in the chair.

After the regular business was transacted, Dr. William Speakman, of Philadelphia, gave a most interesting lecture on "The Eye from the General Practitioner's Standpoint." This was illustrated with colored slides.

After the lecture there was a general discussion at which several practical points were brought out, and Dr. Speakman received a rising vote of thanks for his efforts.

Those present were Drs. Hilliard, Ewen, Davis, Hummel, Church and Smith, of Salem; DeGrafft, Hasted and Thomas, of Woodstown; Fleming, of Pennsgrove; Davies, of Elmer, and James, of Pennsville.

After the meeting the members enjoyed a banquet at the White Palace Restaurant.

The next meeting will be held on February 14 at the Memorial Hospital, Salem.

Local Medical Society Reports.

Hackensack Hospital Staff.

The last regular meeting of the Associated Physicians of the Hackensack Hospital was held at the Hackensack Hospital on December 1, 1922; President Edwards, presiding.

Scientific Programme.—Dr. Conrad suggested that many fracture cases are discharged from the hospital which could be improved by open operation. He discussed fractures of the humerus, then followed with demonstration of case of bone-graft in tibia following osteomyelitis. He demonstrated case of T. B. of knee in which resection and bone-graft were performed; also case of fracture of lower end of femur with pushing of epiphysis backward. In this case the entire joint was opened, the epiphysis brought forward and nailed, with very good result. Dr. Conrad thinks irreducible fractures should be treated by bone surgery.

Dr. Corn demonstrated a case of fracture of tibia and fibula which was treated by wiring; about one-third of the opposed surfaces were coapting; the result was good. Dr. Essertier reported case of compound-comminuted fracture of the tibia and fibula, which was finally bone-plated with probably good result. Dr. Finke gave a general review of fractures. He stated that from the Mayo Clinic comes news that the endosteum of bones in grafting should

be in direct opposition for good results, for here the osteoblasts form. He reviewed the case of a man whose hand was caught in a rolling machine and resulted in many fractures of the bones of the hand, fracture of humerus, and compound fracture of lower jaw, the latter having been wired.

Practitioners' Society, Eastern Monmouth.

D. M. P. Magee, M. D., Secretary.

The regular monthly meeting of the Practitioners' Society of Eastern Monmouth was held at the Monmouth Memorial Hospital at Long Branch on December 28. The newly-elected officers: Dr. William G. Herrman, president; Dr. William K. Campbell, vice-president; Dr. David M. P. Maghee, secretary, and Dr. James J. Rowland, treasurer, assumed office. In spite of the night being the worst that this winter has yet given us, the meeting was very well attended. Dinner was served, followed by a short entertainment, both of which were enjoyed immensely. This was followed by a very interesting and instructive paper on the subject, "Bronchoscopic Treatment and Drainage of Pulmonary Abscess and Bronchiectasis," by Drs. William F. Moore and Robert M. Lukens, from Dr. Chevalier Jackson's Bronchoscopic Clinic, Jefferson Hospital, Philadelphia. The paper was accompanied by lantern slides.

This society was started years ago for the practitioners of eastern Monmouth County to further the social life between them and to serve as a means to bring before them scientific discussions. The organization has had a number of prosperous years, but this promises to be the best, and we look forward to many interesting evenings and discussions during the current year.

SUMMIT MEDICAL SOCIETY

William J. Lamson, M. D., Secretary.

The regular monthly meeting of the Summit Medical Society was held at the Canoe Brook Country Club on Friday, November 24, 1922, at 8:30 P. M. Our host, Dr. Krauss, was in Europe, but had arranged for the meeting before his departure. In the temporary absence of the president and vice-president, Dr. Keeney occupied the chair.

Letters of resignation from the society were read from Drs. Johnson and O'Reilly, and their resignations were accepted, with regret. Dr. R. S. Milligan, of Summit, was nominated for membership in the society. Dr. T. H. Rockwell, a former member, who has recently returned from New York city to Summit, was elected an honorary member of the society.

The paper of the evening was read by Dr. George S. Reitter, of East Orange, radiologist to Overlook Hospital, on "The Treatment of Uterine Hemorrhage of Benign Origin With Radium." He said that radium has a very definite therapeutic value in certain menorrhagias and metrorrhagias not associated with fibroid, such as excessive flow in young girls, where the dose must be very small, and in severe dysmenorrhoeas or chronic metritis, where large doses may be used to produce an artificial menopause. The results are very good. In hemorrhage, due to fibroids, of in-

terstitial origin, where the patient is over forty or a poor surgical risk, or where operation is refused, radium is used with brilliant results. Hemorrhage is relieved in 96 per cent., shrinkage occurs in 70 to 80 per cent. and the mortality is about 1-500 (as compared with 1 per cent. to 2 per cent. in operative procedure). The advantage of radium in these cases is that there is no mutilating operation, the stay in hospital is short, and there are no severe or protracted sequelae.

December Meeting.

The combined meeting of the Summit Medical Society and the medical staff of Overlook Hospital was held at the hospital on Friday, December 29, 1922, at 8:30 p. m. Present: Drs. Alexander, Baker, Bensley, Bowles, Falvello, Krauss, Lamson, Moister, Morris, Prout and Tidaback, and Dr. Chamberlain, of Maplewood.

Dr. R. S. Milligan, of Summit, was unanimously elected to membership in the society.

Informal discussion of the medical library was then taken up, and on motion, the president, Dr. Moister, appointed a permanent library committee, with power, consisting of Drs. Baker, chairman; Prout and Alexander, to proceed with the matter of equipping the room in the library for the reception of books and magazines, and to report at the next meeting as to budget, dues, etc.

January, 1923, Meeting.

A regular meeting was held at the Canoe Brook Country Club, January 26, 1923, Dr. Tator entertaining and Dr. Moister presiding. Dr. Bert A. Praeger, of Chatham, was nominated for membership.

The paper of the evening was read by Dr. George P. Laidlaw, of New York city, on "Angina Pectoris." He described two different types of the disease: 1. Effort angina; 2. Decubitus angina. Effort angina is produced by muscular exertion, and is caused by dilatation of the base of the aorta, with reflex pain radiating down the left arm. A large percentage of these cases is due to syphilitic aortitis. The attack is best treated by general vaso-dilatation by amilnitrite, or nitroglycerin, followed by sodium nitrite or sodium iodide. Coronary dilatation does not satisfactorily explain this condition. Pseudo-angina is really a misnomer. Decubitus angina comes on suddenly without exertion, and is due to an acute dilatation of the left ventricle, with edema of lungs and syncope, the pain is distributed over a larger area than in effort angina. Treatment calls for relief of pain by morphine, bleeding and subsequent digitalization.

Dr. Laidlaw ably presented his subject, and he recommended as the best work on cardiac conditions the new book by Vaques, of Paris, which is soon to be published by Saunders, of which he is the translator.

West Hudson Practitioners' Club.—This club met December 26 at the home of Dr. M. F. Squier, in Harrison. Dr. John Toye, of Arlington, read a paper on "Early Recognition of Certain Orthopedic Conditions and Their Treatment."

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Each member of the State Society is entitled to receive a copy of the JOURNAL every month.

Any member failing to receive the paper will confer a favor by notifying the Publication Committee of the fact.

NOTE.—The transaction of business will be expedited, and prompt attention secured if,—

All papers, news items, reports for publication and any matters of medical or scientific interest, are sent direct to THE EDITOR, New Brunswick.

All communications relating to reprints, subscriptions, changes of address, extra copies of the JOURNAL books for review, advertisements, or any matter pertaining to the business management of the JOURNAL are sent direct to THE CHAIRMAN OF THE PUBLICATION COMMITTEE, Newark

ANNUAL MEETING OF THE STATE SOCIETY.

The next annual meeting of our State Society will be held in Haddon Hall, Atlantic City, N. J., June 21, 22 and 23, 1923. The hotel offers very reasonable rates and best possible provision for our care and comfort. There will doubtless be a very large attendance.

ANNUAL MEETING OF A. M. A.

The next meeting of the American Medical Association will be held at San Francisco, Cal., during the week of June 25, 1923. Several of our members are planning to attend and there would be many more if it did not occur about the same time that our own State Society meeting will be held. See notice on page — of a special train, which offers splendid opportunity for visiting the far West and North West, taking a month for the trip.

OUR LEGISLATIVE BILLS.

The legislative bills backed by the Welfare Committee and known as the Marriage Certificate bill and Venereal Disease Control bill were introduced in the Senate, Monday night, January 22, 1923, by Dr. Horace Fooder, senator from Gloucester

county. The Marriage Certificate bill is Senate No. 143, and the Control bill is Senate No. 144. It will be the aim of the Welfare Committee to at once launch the campaign for the passage of these measures. The Legislative Committee of each county medical society is urged to present the case to the senator from its county and ask for his support. (See Welfare Committee report, page 70).

DR. HARRY A. STOUT.

Our State Society has met with a great loss in the death of Dr. Stout. He had proved his worth in the minor positions held in the Society after his graduation in medicine, that he was elected Corresponding Secretary at the annual meeting in June, 1908, and he filled that position until his death with conspicuous ability. He was a model family physician. We had the sad privilege of attending his funeral at Wenonah. His pastor's remarks concerning his fidelity in his profession, and in Christian work reminded us forcibly of the remarks at the funeral of Dr. Whitenack at Newark by the latter's pastor as given in our January Journal.

SIGNS OF PROMISE.

It is one of the most hopeful signs for our profession's future welfare to note the increasing attendance on and interest in the work of some of our county medical societies. We trust it is but the beginning of new life that shall continue during the whole new year, and that every county society shall catch the spirit of the few already showing that they are beginning to realize the splendid opportunities and the great responsibility of membership in a profession that means so much to the national life and humanity's welfare. One of the most important duties that is needed is the increase in our membership. We ought to, and can if we so resolve, come up to our next annual meeting with 500 additional members. The next duty in importance is to get our members to attend the county society meetings, but of that we speak in our next editorial. Let us remember that we are members of a noble profession, not of a mere trade—in business to make money for selfish purposes. It is said "the love of money is the root of all evil," but it is only a root, we believe, of the most cursed evil—*selfishness*, from which other evils come.

HAVE YOU PAID YOUR DUES?

"I DON'T READ MEDICAL JOURNALS." "I DON'T ATTEND COUNTY SOCIETY MEETINGS."

We had part of an editorial written on the above remarks we have heard a few members have made—mostly in former years—but we have since received a letter from a prominent business man who is a subscriber to our Journal, and as he gives stronger words than we would use, we insert most of his letter, as follows:

Dear Dr. English: I see in the January Journal that you propose to speak of the doctors who say they "don't read medical journals and don't attend medical society meetings." I think such an editorial is needed, and I hope you will speak plainly and decidedly in antagonism to the attitude of doctors who have so little regard for the lives and the health of patients and of the community, as to give little or no attention to the wonderful progress your profession is constantly making. I am a busy business man, with a wife and several children, and I say decidedly that no doctor will ever enter my home as family physician who does not read medical journals and does not attend medical society meetings. The lives of my dear ones are too precious to be trifled with. Such doctors ought to remove to the backwoods, or to Central Africa or some other benighted region.

We have but few comments to make on this letter. We think the number of members who do not read our Journal is growing less every year. The new Directory of the A. M. A. says: "Read by practically every physician in the state. Full of valuable articles and carrying important advertisements all of vital interest to the profession." Possibly not as much careful thought is given to its Original Articles and Case Reports as should be given.

The matter of attending County Society Meetings is more serious because of the large number of absentees. Probably not more than 30 per cent. attend with any degree of regularity. This condition demands careful thought and correction. We think more carefully prepared programs are needed, with brief, practical papers, cases reported and discussed, etc., the meetings being somewhat of a post-graduate course, making more intelligent practitioners. Then the time of holding society meetings needs our careful thought. For example—not to multiply words: The Editor attended a meeting in one of our large counties called at 8.30 p. m., the president came in at 8.50, the secretary at 9:05; not a member was

present from the western end of the county, not five from the central part and not one-half of the doctors of the city in which the meeting was held. Was that practically saying to the members, we don't expect you to attend. Some say an annual meeting; "other meetings at the call of the president." Would it be better to have quarterly meetings at an hour that would suit most members—say at 1 p. m. with luncheon, or 3 or 4 o'clock? and meetings held in different sections of the county? These suggestions are offered as worthy of some consideration even if not approved. We need business methods and work done in a business-like way.

One other word—our business man friend says in his letter that our members who do not read medical journals or attend medical meetings "ought to remove to the backwoods," if he means in the woods where no light comes, to cut wood and cultivate the soil, all right. But if he means to remove to the country and practice medicine, we differ with him decidedly. Our physicians who practice in the country do read medical journals and attend medical society meetings and as a rule are as able and successful as others, and to be preferred to city doctors who do not read medical journals or attend medical society meetings—nor would we send the latter class to "Africa or other benighted regions." We sent our best to the Panama Canal region; our Christian Missions are sending our ablest physicians and nurses to establish hospitals and introduce sanitary measures in heathen lands and it has produced wonderful results—New Jersey has sent several such doctors and nurses.

We will keep the other class among us to be taught some lessons by our business men who are beginning to discriminate between our ablest and busiest doctors who take time to read medical journals and attend medical meetings, and those who do not take time to do so. Heretofore our profession has suffered too often in public estimation from erroneous judgment based on the lives and actions of the latter class; on the few who were believed to be careless or mercenary in giving medical testimony in law suits unduly favorable to the party that employed them, and on the very few others who performed criminal operations. The public generally does not know that the two

latter classes are almost entirely composed of irregular doctors who are not eligible for membership in county societies and therefore the whole medical profession is misjudged. We believe that those days are passing as the members of our noble profession take their stand more firmly for Truth and Right, like Louis Pasteur—unselfish, fearless and tireless in the defense of truth, "God and Work" was his motto and "We Must Work" his last words.

We regret exceedingly the delay in inserting Original Articles. It is due to the large number of them we have received during the past three months. We have now on hand enough to fill two issues of the Journal if we should leave out all other reading matter. We are, therefore, compelled to ask secretaries of our county societies not to send, for the present, any more unless they are very brief and are such as would be unusually helpful to our members, as we have intimated in an item at the end of page 66.

CORRESPONDENCE.

Infectious Jaundice.

To the Medical Society of New Jersey Journal:

The undersigned is desirous of obtaining information regarding the prevalence of Infectious Jaundice in your State.

The disease is non-reportable and information regarding its prevalence cannot therefore be obtained from Boards of Health. I shall be grateful for any reports of outbreaking which your readers may care to send me.

Address, George Blumer, M. D.,
195 Church St., New Haven, Conn.
By H.S.

Academy of Medicine, Northern New Jersey.

The stated meeting of the Academy will be held on Wednesday, Feb. 21st, at 8.45 P. M. After regular business the paper will be read by Dr. John A. Fordyce, of the College of Physicians and Surgeons, N. Y. City, on "The Prognosis of Syphilis," with lantern slide demonstration.

The Section on Eye, Ear, Nose and Throat will meet on February 12th at 8.45 P. M. After report of cases, Dr. Ross Faulkner will read a paper on "The Principles of Treatment of Sinusitis."

The Section on Medicine and Pediatrics will meet February 31th at 8.45 P. M. After report of cases, a paper will read by Dr. F. C. Horsford on "Vascular Hypertension and Aortitis." It will be discussed by Dr. M. J. Fine and others.

The Section on Obstetrics and Gynecology will meet February 27th at 8.45 P. M. Dr. S. A. Cosgrove of Jersey City will read a paper, after the report of cases.

The meetings will all be held in the Academy building, 91 Lincoln Park, Newark.

Report of the Annual Meeting of the Middlesex County Tuberculosis League.

The annual luncheon meeting of the Middlesex Tuberculosis League was opened by Dr. C. I. Silk, the president, who welcomed those present and announced that a very successful Xmas Seal Campaign had just been concluded a few reports of the method of, "Carrying On," would be heard.

Dr. B. W. Hoagland spoke of the mail sale. A mail sale is preferable to a large committee smaller personnel for its management. The mail sale as it requires less organization and a sale letters were prepared this year entirely by a mail sale house, outside of the office. This was done in order to enable the nurses to carry on their routine work, and to leave the executive secretary free for the organization sale in booths, schools and industries. The total reported for the sale by the executive secretary, Miss Jane J. Packard was slightly in excess of \$10,000.

Mrs. M. M. Lederer, president of the Council of Jewish Women in New Brunswick, reported on the success of the council in the booth at the Post Office.

Mrs. J. B. Josselson and Mrs. D. Wilentz gave an account of the work accomplished by the Council in Perth Amboy at the National Bank.

Dr. Silk then introduced T. B. Kidner, institutional secretary of the National Tuberculosis Association and consultant to the United States Public Health Service of Hospital Planning. He congratulated the Middlesex County Tuberculosis League on having such well-developed finding agencies. He emphasized the necessity of tuberculosis wards in general hospitals and the provisions of training facilities for physicians and nurses along the lines of tuberculosis.

Mr. Kidner outlined the history of sanatoria from the time of Dr. Trudeau until the present day. Due to lack of planning and change in hospital standards sanatorium buildings have been re-modelled and changed so that many sanatorium grounds present many different types of building.

A county hospital should be large enough to include a bed for every death in the county. The site should be determined by accessibility, rather than by climate. Nearness to water, light and sewerage lines are all important. A tuberculosis hospital should not be associated with the jail, institution for paupers, etc. The site should include proper building area for new buildings. The building should be modern and the scenery as attractive as possible.

Miss Emily Halsey Suydam of the New Jersey Tuberculosis League, told of her interest in the work here, as she had been first organizer for the county.

Mr. William S. Day, Director of the Board of Freeholders declared that the Freeholders were unanimously in favor of a hospital, but urged that the sanatorium be built in conjunction with other county hospitals.

County Treasurer Hilker spoke of the many propositions necessary for the Board of Freeholders to consider. He stated that he regarded the tuberculosis problem as being among the more important of these. There is only one-half million dollars available for

all purposes however, and a small sanatorium unit should be built first and then added to.

Mr. Wilton T. Applegate, Assemblyman, eulogized the excellent work done by the League and Mr. John T. Manley of New Brunswick, spoke in favor of a joint hospital.

Dr. D. C. English concluded the meeting with some very forceful and striking remarks. "It is not a question of funds," said Dr. English, "the law states that such a building must be constructed." It should be a matter of local pride for a large county, such as Middlesex, to have a hospital of its own. He maintained that the lives and health of the public is far more important than anything else that could be considered by the Freeholders and that good roads not be built at the expense of the lives of the citizens.

President Silk's address will be published in the March Journal.

Law to Prevent Rabies.

The following bill has been introduced in our State Legislature and should be enacted:

Be it enacted by the Senate and General Assembly of the State of New Jersey:

1. No license to keep a dog or dogs shall hereafter be issued in this State, unless and until the applicant therefor shall produce and file with the licensing officer a certificate from a registered veterinarian of this State requiring that such dog sought to be licensed has received an anti-rabies vaccination treatment within one month prior to such application.

2. This act shall take effect immediately.

Statement.—Rabies, or hydrophobia, is an infectious disease transmitted by dogs to human beings and is always fatal. It causes untold suffering and results in a tragic death, either in children or adults. It has been proven that it can be eradicated entirely by a law such as this act provides.

MEDICAL DEFENSE AND INDEMNITY INSURANCE.

Up to the present time 100 members of the Medical Society of New Jersey have availed themselves of indemnity insurance in connection with the new plan of medical defense adopted by the Society at its last annual meeting.

In the Journal of the Medical Society of New Jersey, published in October, 1922, this plan, containing the agreements made with the United States Fidelity and Guaranty Company, of Baltimore, through its New Jersey agent, Louis O. Faulhaber, was set forth in detail as a part of the report of the Committee on Medical Defense and Indemnity Insurance. According to the resolution of the Society, the plan, agreements and contract were submitted to Albert C. Wall, the legal counsel of the Society, and approved by him and by the Board of Trustees.

It would seem that many members do not understand clearly this form of insurance for medical defense, particularly with regard to the terms of contract, the dates and the agency authorized to handle it. As the report of the committee has set forth definitely no member is compelled to take out a policy, but it is absolutely necessary for the purpose

of fulfilling the contract made by the Society, and as a matter of good faith, that the members should obtain their certificates from the agent authorized by the company to act on its behalf.

To be entitled to the benefits of the coverage secured under the contract a member must be a holder of a certificate under the group policy issued to the Society and held by the Recording Secretary, as trustee. Members who are otherwise insured will not have the advantages gained by the group contract plan. It has become necessary to set forth this matter clearly, because of a situation that has been created in some of the counties, as the result of another agent offering a different form of contract, as regards rates for those using x-ray, violet ray and radium, for therapeutic purposes.

Under the Society's contract with the company a minimum or basic rate of \$18 per annum for limits of \$5,000 for one suit and \$15,000 for three suits during the year was applied to all members. An additional 50 per cent. of the premium was charged for coverage of those engaged in x-ray, violet ray and radium work, on account of the extra hazard. In view of certain conditions that have developed, through a series of misunderstandings on the part of the company, the company has decided to grant the coverage to all the members of the State Society for a flat rate of \$18, regardless of the kind of treatment given. In other words, the original additional charge for the use of x-ray, violet ray and radium in treatment has been withdrawn.

The Board of Trustees at a regular meeting held on December 23, 1922, at the Academy of Medicine of Northern New Jersey, Newark, passed a resolution, urging the importance of members availing themselves promptly of the indemnity insurance form of medical defense, both for their own protection and for the relief of the Society from the increasing and burdensome cost of medical defense, under the old malpractice act. In one case contested since 1917 and recently brought to a favorable termination, the cost to the Society amounted to nearly \$2,000, because it had to be defended thrice in the lower courts and then taken on appeal to a higher court. A part of this expense may have to be borne by the defendant member. In another recent case two members, who were jointly sued and successfully defended by the Society, had to pay a sum of \$350 in excess of the allowance of the Society for the expense incurred in the trial court.

It is, therefore, important that the members of the Society, who now feel secure in the protection offered under the Medical Defense act, should not fail to remember that the Society's limit of expenditure in the trial court is \$250. Expenses in excess of this amount and the cost of damages arising from an adverse verdict have to be paid by the member defended.

While the Society has been fortunate up to the present time in the defense of malpractice suits, changed conditions compel the consideration of the repeal of the Medical Defense act. The solution of the problem, as it concerns the Society, as a whole, and its

members individually, lies in the prompt acceptance of medical defense with indemnity insurance under the group plan.

Members desiring further information regarding medical defense and indemnity insurance should communicate with Dr. C. C. Beling, 111 Clinton avenue, Newark, N. J., chairman of the Committee on Medical Defense and Indemnity Insurance, or with Louis O. Faulhaber, general agent, United States Fidelity and Guaranty Company, 11 Clinton street, Newark, N. J.

WELFARE COMMITTEE MEETING.

A meeting of the Welfare Committee of the Medical Society of New Jersey was held at the Essex Club, Newark, on January 12, 1923. Those present were Drs. Wells P. Eagleton, Newark, chairman; Frank W. Pinneo, Newark; A. Haines Lippincott, Camden; George T. Banker, Elizabeth; Thomas Harvey, Sr., Orange; Henry B. Costill, Trenton; Frederick J. Quigley, Union Hill; D. C. English, New Brunswick; John McCoy, Paterson; Julia Mutchler; Dover. Others present were Drs. Spence of the State Board of Health; A. J. Casselman, Venereal Disease Bureau, State Board of Health; H. B. Kessler, Newark Maternity Hospital; H. S. Forman, Jersey City; E. B. Grier, Elizabeth; Mr. Haydon.

Report was made of the introduction of three bills into the legislature by the State Board of Medical Examiners, viz.: \$10,000 appropriation bill to conduct prosecutions for violations of the Medical Practice Act; to provide for free R. R. passes for members of the State Medical Board; for changing periods of instruction of midwives. Dr. Eagleton stated that these bills were not introduced at the request of the Welfare Committee.

Dr. Spence spoke of a midwifery bill which the State Department of Health had in mind and which would place the control of midwives under the State Department of Health. On motion by Dr. McCoy, seconded by Dr. Banker, Dr. Spence and Mr. Quigley were authorized to consult with counsel for the purpose of drafting a bill covering the midwifery question and submit it to the Welfare Committee for its approval.

On motion by Dr. McCoy, a letter of Dr. Dickinson's regarding the control of nursing homes, baby farms and private sanatoriums was referred to the Hospital Standardization Committee.

Dr. Eagleton explained the proposed Venereal Control Bills, including a marriage license certificate bill and a control bill. There was a general discussion of the measures, after which the committee voted to indorse the control bill as presented, and the marriage certificate bill as introduced to the legislature last winter, including the physical examination form. On motion the chairman was authorized to have Mr. Striker, lawyer, put the bills into form for introduction into the legislature.

Dr. McCoy reported on a conference between the members of the Hospital Standardization Committee and a delegation of nurses representing the New Jersey State Nurses' Association, at which proposed changes in the nurses' practice act was discussed. Nothing

definite was arrived at and the conference is to be continued.

On motion the committee voted not to introduce a venereal disease reporting bill at this session of the legislature, but recommended a further study of the situation be made that at some time a change may be made in the manner of reporting such cases.

On motion it was ordered that copies of the bills to be introduced into the legislature by the Welfare Committee be supplied to each county medical society, with an explanation of the provisions of each and asking for the approval of the bills by the county medical societies.

On motion it was directed that copies of the venereal disease control bills be supplied to the women's organizations throughout the State.

Hospitals.

Hackensack Hospital.—Superintendent Stone reports for December: Major operations, 35; minor operations, 54; deliveries, 25; deaths, 21; ambulance cases, 55; x-rays, 226; radium cases, 13.

City Hospital, Newark.—Plans have been approved for the building of the new wing of this hospital, at an estimated cost of \$325,000, which will occupy 128x45 feet, and contain 100 beds.

Newark Babies' Hospital.—A campaign is being conducted by a committee, of which Dr. Carl E. Sutphen is chairman, to raise from \$60,000 to \$75,000 for a wing to the hospital, as a memorial to Dr. M. Royal Whitenack, who died recently. Several thousands of dollars have already been subscribed.

Salem County Memorial Hospital.—Dr. W. H. James sends the following report of this hospital for the month of November: Admissions, 40; discharges, 39; births, 6; deaths, 0; accidents, 13; patients treated at clinic, 37; xrays, 17; operations, 18.

Warren County Hospital.—A campaign has been started to raise \$50,000 for the hospital to be established at Phillipsburg, with an effort to secure ten \$100 life members.

BONNIE BURN SANATORIUM

Superintendent J. E. Runnells, M. D., reports that on November 1 there were 235 patients in the sanatorium; 140 males and 95 females. During the month thirty-three patients had been admitted, sixteen males and seventeen females. Fourteen of these admissions went to the preventorium. Among these admissions there were eight re-admissions. The admissions are classified as follows: Pretubercular, 15; incipient, 1; moderately advanced, 4; far advanced, 13.

In the sanatorium, November 30, 1922, 242. This includes seventy-four children in the preventorium and seventy-three out of the county patients.

Deaths.

FITHIAN—At Camden, N. J., December 9, 1922, Dr. Joel W. Fithian, aged fifty-eight years.

SLACK—At St. Petersburg, Fla., January 28, 1923, Dr. Clarence M. Slack, of Belmar, N. J., formerly of New Brunswick, aged eighty-two. Funeral notice next month.

STOUT—At Wenonah, N. J., January 14, 1923, Dr. Harry A. Stout, aged fifty-eight years.

Obituaries.

DR. JOEL W. FITHIAN.

The Camden County Medical Society adopted the following minute:

The Camden County Medical Society has learned with regret and a sense of loss, poorly expressed in words, of the death of one of its most active members,

Dr. Joel W. Fithian.

Thoroughly human and companionable at all times, Dr. Fithian, nevertheless, possessed a striking personality, and he was untiring in following what he believed to be his path of duty. His distinguishing trait was unfaltering loyalty to his convictions, and yet he displayed breadth of mind and kindness of heart in the fact that he could disagree with those about him without acrimonious feeling. He never permitted his opinion to dominate the native gentleman in him.

He devoted himself especially to the study of obstetrics and here he made and followed his own observations, and very often with striking success. His ideal was the scientific method, and he would have said with Horace:

"Si quid novisti roctius istis

Candidus importi, si non, his utere mecum."

His human, companionable, side was nowhere displayed so strongly as in his love of children. The unrelenting student and hard-working practitioner in him always yielded to the blandishments of childhood, and no father could have been more solicitous for his little children than Dr. Fithian for the recovery of a tiny patient. As the superintendent of the Camden County Sanatorium for Tuberculosis Patients, he took a personal interest in all and strived to provide many minor comforts, while his cheerful philosophy was reflected in the sub-name of the institution, "Sunny Rest."

His memory will live in evidences of his learning, absolute sincerity and devotion to duty.

Alexander MacAlister, H. F. Palm, E. G. Hummel, Committee.

HARRY A. STOUT, M. D.

Dr. Harry A. Stout, an eminent physician of Wenonah, Gloucester county, New Jersey, died suddenly, Sunday, January 14th, 1923, from disease of the heart, age 58 years.

Dr. Stout was the son of Dr. Mulford and Ellen Hough Stout of Berlin, where he was born November 28th, 1864. He attended the

Friend's Central School of Philadelphia, then entered the Jefferson Medical College, graduating with honors in the class of 1886. He settled in Wenonah immediately following graduation and entered upon the practice of medicine. The following October, he married Laura A. Wilson, daughter of the Rev. Thomas A. and Christine Combs Wilson of Berlin, N. J.

Alert, diligent, industrious and painstaking, devoted to his profession, he quickly acquired an extensive practice. He inspired his patients with such confidence that loyalty and fidelity became their attitude toward him in every particular. Seldom does it fall to the lot of the physician in general practice to secure this spirit upon the part of patients so marked a degree. Children were quick to perceive and return his sincere love for them and if he excelled in any given line of practice it was in pediatrics. His life work was in religion, whether by night or day, in storm or sunshine, heat or cold, a call from the sick distressed always met with prompt response. He never spared himself, but gave freely the best that was in him to those calling upon him for help; living at all times, even to the very end, "The true life of service" to which Cole refers when he says:—The good life is the life that reaches out, that fulfils itself, ministrations to other lives. The life that counts most is the life that serves most."

Aside from his professional work, he took an active interest in all civic, social and religious matters. Politically a life long republican, he served his community, county, state and Federal governments, as Coroner, Councilman, member of the Board of Education (18 years,) of the State Board of Medical Examiners of New Jersey, medical school examiner, member of the Draft Board during the war, volunteered and was accepted for medical service during the World War. For many years corresponding secretary of the Medical Society of New Jersey. Served upon the Official Board of the local M. E. Church for thirty-seven years and was also a member of the following organizations:—A. M. State and County Medical Societies, Philadelphia Medical Club, Physician's Motor Club of Camden, Physician's Association of Wenonah, Mantua Lodge F. & A. M., Excelsior Consistory, Crescent Temple (A. A. O. N. M.).

He is survived by his widow, Laura, daughter Elinor, and son Dr. H. Wilson Stout of Wenonah.

Buried Wednesday, January 17th, 1923, Wenonah cemetery.

"A few who have watched me sail away
Will miss my craft from the busy bay;
Some friendly barks that were anchored near
Some loving souls that my heart held dear
In silent sorrow will drop a tear—
But I shall have peacefully furled my sail
In moorings sheltered from storm or gale,
And greeted the friends who have sailed before
O'er the Unknown Sea to the Unseen Shore

—J. Hunter, Jr., M. D.

The State Medical Board recently refused to reinstate a Newark medical practitioner who was convicted, in 1920, of having performed an illegal operation.

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SOME MODERN VIEWS ON BLOOD PRESSURE.*

By Francis Ashley Faught, M. D.,
Philadelphia, Pa.

The subject that has been assigned to me is one of interest to every practitioner of medicine, irrespective of his specialty, as there is no other one pre-cisional method that enjoys such universal employment. The rapidly accumulating volume of literature pertaining to the employment of the sphygmomanometer forces me to confine my remarks to certain phases of the subject, although I have endeavored to include most of the newer views on blood pressure, modified in some instances, by an expression of personal opinion, based upon my own experiences. Generally speaking, my paper is in the nature of a summary of current literature on this subject, and should in no way be considered an exhaustive discussion.

Normal Averages and Variations.—

There is still much discussion as to what normal systolic pressure values should be assigned to any given age. My personal feeling is that there has been "much adieu about nothing," as it is impossible to assign any very fixed normal values to such a variable factor as the systolic pressure. The question is further complicated by a tendency on the part of the insurance companies to place definite and narrow restrictions around the systolic level, as applied to life insurance examinations, while at the same time clinicians are leaning toward a latitude even broader than that now considered permissible. We should not permit the dictum of the insurance com-

panies to unduly influence our clinical judgment, it being a mistake to give undue weight to slight or transitory systolic variations unless supported by the general clinical picture. Up to the present writing there seems no reason to depart from the oft quoted chart of Woley and the table of Fisher, which closely parallels it.

My own studies of a large number of normals suggested a formula, first published in 1909, whereby a rough estimate of normal age values for the systolic pressure and its normal variations could be determined. I have here a table giving the averages of the chart of Woley converted into a table and have arranged in parallel columns with this, the figures of Fisher and those obtained by my formula. In this table it will be found that there is but slight difference in the age levels as determined by Woley, Fisher or myself, each table being a safe guide to the physician. The particular value of the formula is that it allows an immediate determination of the normal average and its probable normal variations in any case without the necessity of remembering a number of figures or having to recourse to a table.

Some Sources of Error in Blood Pressure Examinations.—

Despite the fact that we are all familiar with the use of the sphygmomanometer, I would call your attention to the fact that the **psychic factor** in the patient may be greater than is usually supposed, causing, in some cases a transitory systolic rise of 40 or 60 mm Hg. Thus a systolic of 170 mm Hg. may on repeated observation be found to average 120 mm Hg. **Complete relaxation** of the patient is necessary in order to avoid a possible systolic error of from 5 to 15 mm Hg. due to general muscular contraction, or increased abdominal tension. **Edema** of

*Read by invitation before the Tri-County Medical Association of New Jersey at Hackettstown, October 17, 1922.

the part to which the cuff is applied, even when barely noticeable, introduces a systolic error of from 10 to 30 or more mm Hg.

Rapidly repeated or prolong compression of the part, at one sitting, may increase the systolic pressure by 5 or 10 mm Hg., while fatigue during examination may cause the systolic pressure to fall 10 or 15 mm Hg. The average difference in normals between the two arms is very slight, in most cases not over 1 or 2 mm Hg., though occasionally amounting to 5 mm Hg. systolic. In the aged, especially in arterio-sclerosis, the difference may be great (as much as 50 mm) affecting the systolic pressure particularly, while the diastolic pressure maintains a surprising uniformity. The difference in pressure in normals between arm and leg readings is rarely more than a few millimeters, being equal to the difference in the weight of the column of blood for the position in which the observations are made.

Hypotension.—The increasing frequency of reports of conditions presenting low blood pressure has added to our general knowledge of hypotension and its significance. It should be borne in mind, however, that many conditions which are usually associated with reduced systolic pressures, may be obscured by other conditions which neutralize this effect and render its detection difficult.

In tuberculosis the belief continues that a low systolic pressure and a small pulse pressure are significant of an active process, while a rising systolic and an increasing pulse pressure is of good omen, when occurring in the course of an acute tubercular infection, whereas, a progressively falling systolic with a small pulse pressure is of grave significance. A most common cause of transitory hypotension is a temporarily weakened myocardium and an inactive vasomotor system resulting from recent acute infections. Addison's disease is always associated with systolic pressures below 100. One should guard against attributing undue significance to a subnormal systolic taken during hot weather as it is well demonstrated that the relaxing effect of external heat may temporarily produce a marked reduction in systolic pressure. Neuresthenia while classed among low pressures, does not always fall into this category, as cases will be met which maintain an elevated systolic for months at a time.

There is a fairly common type of individual who presents a persistently low systolic pressure, a small pulse pressure with a variable pulse rate, tending toward rapidity. Such persons have no significant past medical history, although they may never have been in robust health. They constantly complain of vague and variable symptoms. Physical examination fails to show any abnormalities except a slightly reduced red-cell count and hemoglobin deficiency. They complain of always being tired and easily fatigued. Splanchnic stasis and colon retention may usually be demonstrated by x-ray or by the improvement following the application of adequate support, graduated systematic exercises and improved regime. These cases have been grouped under the head of **adrenal deficiency**. Recently C. H. Lawrence reported 20 cases which fell into this group, with autopsy verification in two.

Myocardial Efficiency; Cardiac Output and Cardiac Reserve.—No one has yet succeeded in perfecting a formula that can be depended upon to clinically estimate myocardial efficiency, cardiac output or cardiac load. The number of separate but closely correlated factors involved in the maintenance of normal blood pressure values, and the obvious impossibility of determining these accurately, or of expressing heart work or muscular efficiency in terms of blood pressure explains the futility of such efforts.

For example, how can any formula, which ignores the systolic pressure level, be of value in estimating heart work? Does not the heart perform work from the moment of beginning systole, so why ignore the diastolic pressure in the calculation, as some formulas do? Is not the pulse pressure largely controlled by peripheral resistance, which in turn is closely related to the elasticity and tonicity of the larger vessels together with the ever varying permeability of the minute arterioles and the capillaries, rather than on the minute volume output of the heart? And again, can any one of these factors be even approximated? These questions are merely a repetition of what I have taught and published for a number of years, for I am convinced that any attempt to employ such formulas in clinical diagnosis must without exception lead to dangerous clinical errors, through unavoidable miscalculations.

We are however, able in a general way, to note the effect of graduated effort upon the several blood pressure values, the pulse rate and the respiration, and by so doing form some opinion of the state of the myocardium i. e., the remaining cardiac reserve. If we accept the fact that the normal heart in a young adult is incapable of permanent damage through muscular strain, we may then compare the action of such a heart, under measured effort, with one supposed to be less efficient, though even here the test is open to the criticism that it is largely one of vasomotor stability. Briefly, summarized, moderate activity in the normal (going up two or three flights of stairs) causes a systolic rise of from 15 to 40 mm. with little change in diastolic pressure, an increase in pulse pressure and in pulse rise of from 20 to 40 beats per minute; these changes subsiding within 3 or 4 minutes. If such effort brings only a slight 5 to 10 mm. systolic rise and if the diastolic pressure remains unchanged or is increased, while the promptness of return to the previous level is delayed, we may then infer a limited power of the heart, whereas if the systolic pressure shows no rise, the pulse pressure becomes smaller and the pulse rapidly persists, the myocardium may be considered in poor condition. All arrhythmias decrease cardiac output, although the increased pulse rate may partly compensate for this deficiency.

Etiology of High Blood Pressure.—

Whether high pressure is primary, to be followed later by evidence of arterial, cardiac or kidney sclerosis, or whether one of the three last mentioned diseases may be singly or jointly responsible for the blood pressure change, continues to be fruitful field for discussion. To ascribe a kidney origin to all pressures permanently above 160 mm. systolic, is to ignore much accurate clinical and experimental evidence to the contrary. It is undoubtedly true that some cases of elevated systolic pressure occur without demonstrable pathology in the heart, kidneys or blood vessels. Nevertheless, most cases will be found to depend upon hypertonus or abnormal vessel wall contraction plus permanent arterial change with or without, cardiac or renal involvement.

Nitrogen retention, shown by high residual nitrogen in the blood and tissue fluids, plays an important part in early

elevations of blood pressure through a reflex irritation of the vasomotor mechanism, but this does not explain the high systolic pressures, some approaching 200 mm Hg., especially in young individuals, in whom no renal deficiency or retention of urinary substances can be demonstrated.

We are still forced to assign a variety of known and unknown chemical irritants, acting through the nervous system upon the very sensitive vasomotor mechanism or upon the vessel wall themselves, as the cause of a primary elevation in systolic pressure, because it has been proven that, even in the nephritic group, with blood nitrogen high and phthalein output low, the systolic pressure bears no direct relation to degree of these changes; accordingly a high systolic with normal non-protein nitrogen and normal phthalein output, does not justify the diagnosis of chronic nephritis. We must, therefore, continue to believe that elevated systolic pressure irrespective of the kidney condition, depends upon a group of toxic irritants arising from a number of dissociated causes, foremost among which we find, nitrogenous retention, oxygen deficiencies, CO₂ excesses, lactic acid, acid phosphates and bacterial toxins in the blood stream.

In this connection the extensive study of McLester (1917) is of considerable interest. Of 678 consecutive patients coming under observation, 124 were found to have systolic pressures varying between 155 and 200 mm Hg. and over, the average age of the combined high pressure cases was 53.75 years. The relation of previous medical and social history of these high pressure cases was as follows: Typhoid fever in 33, pneumonia in 14, yellow fever in 3, recent scarlet fever in 3 and excessive alcoholism in 6. A positive Wassermann was obtained in 21 or 17.5 per cent. of cases. Focal infections: In the tonsils 4 cases, in the sinuses 4 cases, in the appendix 4 cases, in the gall bladder 5 cases, urinary tract 5 cases, diseased teeth 42 cases. There was present enlargement of the heart in 67 cases, albumin was found alone in 29, albumin and casts in 61 and glycosuria in 10 cases. Full calls attention to cases of prostatic hypertrophy with chronic urinary retention resembling chronic uremia, showing increased residual nitrogen and elevated systolic pressure which were promptly relieved by permanent catheterization.

Is Elevated Blood Pressure Compensatory or Conservative?—Many clinicians answer this question in the affirmative, believing that any effort to lower excessive systolic pressure is fraught with dire results to the heart and kidneys. The present preponderance of clinical opinion is to the contrary. Increase of arterial pressure does not exert a compensatory influence over the renal function and does not exert a conservative but rather a destructive influence upon the cario-vascular and renal systems.

Measures directed toward relieving elevated systolic pressure should have for their object the removal of the causes of and elimination of the exciting toxins, rather than the battering down of an elevated pressure by drugging with the many so-called blood pressure reducers, of which the nitrites are a dangerous example. Failure to attempt to reduce abnormal pressures by appropriate means will eventuate in permanent alterations of a sclerotic nature in the vessel walls themselves or in the tissues of the heart and kidneys. The greater the elevation and the more prolonged the action, the greater the damage. Such damage, irrespective of its origin, becomes an additional factor in the production of the abnormal pressure. When this stage is reached the pressure elevation becomes more complicated, since we now have to deal with hypertonic muscular coat contraction plus permanent sclerotic changes. In this stage the most that can be expected is improvement in the pressure level, by removal of the irritating substances, since complete reduction cannot be accomplished because of the permanent changes that have taken place in the circulatory system.

We may conclude therefore, that effort should always be made to reduce excessive systolic pressures. If successful the walls of the arterial tree and the cardiac and renal compensation will be conserved and the decompensation relieved or restored, if not successful, no harm will result.

Arteriosclerosis.—There are several thoughts in connection with arteriosclerosis which are of general interest, the most striking being the fact that palpability of the radial arteries bears no definite relation to elevated blood pressures or to arteriosclerosis. This

point has recently been emphasized by Willcocks, who has reported a study of 104 normal soldiers, 85 per cent. of whom had distinctly palpable radials and 13 per cent. of these showed marked thickening and hardening of the radials; also a study of 77 ex-soldiers who had had neuro-circulatory asthenia, of whom 92 per cent. showed palpable radials, 40 per cent. of those having marked thickened vessels. In neither series did the systolic exceed 160 mm Hg., nor was it found to be higher in those with appreciable vessel-wall thickening as compared with those without.

Inequality of systolic pressure on the two sides is more prevalent in arteriosclerosis than in any other condition. A series of 150 cases were studied, which showed this difference sufficient to be a striking factor in 50 per cent. Such a finding, in the absence of other conclusive evidence, may serve to fix the responsibility upon the arterial walls, rather than upon the kidneys and heart muscle. Another series of 100 cases of arteriosclerosis in men and women in whom marked kidney involvement and aortic insufficiency were reasonably excluded, showed marked bilateral variation with systolic pressures ranging between 200 and 280 mm Hg. One of these, a man age 74 with a pulse rate of 50, is a striking example:

Left arm—S. P. 178, D. P. 104, P. P. 74.

Right arm—S. P. 230, D. P. 104, P. P. 126.

Diastolic inequality in the presence of systolic equality is extremely rare, while even with great systolic inequality the diastolic pressure varies but slightly. Arteriosclerosis is a disease of high diastolic pressures frequently over 100 mm Hg., and large pulse pressures. For example, in a series of 80 cases of arteriosclerosis the systolic pressure was found to be above 230 mm Hg., in 22 and the diastolic pressure amounted to 100 mm Hg., or more in 28, and the P. P. 100 mm Hg. in 30.

Nephritis—(A) Acute Nephritis.—The systolic elevation in acute nephritis is rarely above 180 mm Hg. and in a favorable case responds promptly to treatment, subsiding in from 5 to 10 days. Diurnal variations may amount to 60 mm Hg., the pressure usually being highest in the evening. The incidence of uremia has little effect upon the blood pressure findings, the systolic rarely exceeding

200 mm Hg., although during the convulsive state it may reach 230 mm Hg. The systolic pressure is of no value in prognosticating the incidence of convulsions, being as low as 130 mm. in some cases several hours before the seizures. The albumin percentage tends to follow the systolic pressure curve although it may remain after the systolic pressure has returned to normal. In unfavorable cases appropriate treatment fails to influence the pressure so that repeated observation during the course of the disease may be of prognostic value.

(B) Glomerulo - Nephritis.—Elevated systolic pressure is the rule and may be of value in diagnosis, as this sign may precede impairment of renal function tests. The blood pressure falls in all cases shortly before death, without marked changes in the S. P.: D. P. ratio.

(C) Acute Nephritis in Children.—In children the blood pressure is rarely of prognostic value and of little value in diagnosis. The average systolic rise being not over 20 mm Hg. above normal and the diastolic not over 10 mm Hg., so that, while the pulse pressure may be increased it is not always so, while the difficulty of employing the sphygmomanometer in childhood further reduces the value of the test. There is no relation between the blood pressure and the urinary findings in acute nephritis in children.

(D) Chronic Nephritis.—Fluctuating high systolics are the rule. Systolic pressures of more than 300 mm Hg. are met and borne by patients with a surprising degree of comfort. The arterial changes and myocardial involvement, usually encountered in chronic nephritis greatly complicates the picture. The pulse pressure is usually large and is increased by an accompanying arteriosclerosis, pulse pressures of over 100 are therefore frequent. The greatly elevated pressure values persist until myocardial degeneration impairs the heart function, when a secondary hypotension ensues. Appropriate treatment applied to the heart if successful, restores the previous abnormal but functionally efficient values. Nephritic circulatory stasis influences the diastolic pressure profoundly, diastolic pressure of 180 mm Hg. have been reported.

Diabetes.—Little if any change in systolic pressure will be noted in the average diabetic with cardiac compensation before the age of 30. Statistics show that

between the ages of 31 and 40, 27 per cent. have an increased systolic of between 141 and 180 mm Hg., between 31 and 50 years, 10 per cent. are over 180 mm Hg., between 51 and 60 years, 69 per cent. are over 140 mm Hg. and of these 31 per cent over 180 mm Hg. while in patients over 60 years of age, 54 per cent. are over 180 mm Hg. In acidosis there will usually be noted a marked fall in systolic pressure. It is generally believed that the systolic elevation met in diabetes is merely co-incident, yet there is considerable clinical evidence to support the contention that in over fat individuals, particularly of the female sex, the prediabetic state may be determined by finding an otherwise unexplained systolic elevation, associated with excessive blood sugar but without glycosuria.

Climateric.—Women passing through a normal menopause exhibit a generally variable, systolic pressure and an increased pulse pressure. This pulse pressure may be present in the absence of systolic elevation. It is probable that temporary endocrine disturbances are the cause of the blood pressure changes which are later compensated for by other glands of internal secretion. This would explain the benefit derived from organotherapy during this condition and its controlling effect upon vasomotor and blood pressure changes. This opinion is further strengthened by the fact that, patients with previously scanty or irregular periods, show less than the average blood pressure change at the menopause, while premature change induced by operative procedures accentuates the vasomotor and blood pressure disturbances, as compared with women in whom the change sets in gradually.

Attention is called to the fact that Schlessinger reporting a study of 85 cases, emphasizes the point that definite blood pressure changes met in women during climateric, especially when the systolic pressure persists above the normal level, may be due to pre-existing or concomitant and determinable causes, and warns against the danger of "watchful waiting."

Pregnancy.—In 1912 Haussling announced that the safe limits for blood pressure during pregnancy lay between 100 and 135 mm Hg. systolic. He also stated that the systolic pressure rise often precedes other signs of toxemia except in those rare cases due to disturbed

liver metabolism. In 1916 Iring, after studying 5,000 women during pregnancy, announced that the systolic pressure varied between 100 and 130 mm Hg. in 80 per cent., that it fell below 100 mm Hg. part of the time in 9 per cent. and at times was over 130 mm Hg. in 11 per cent. of normal pregnancies. With certain qualifications these figures still hold true. We believe that a systolic pressure tending to remain below 100 mm Hg. indicates that the patient may be below par, but does not necessarily mean shock or danger during labor.

A high pressure in young women is more serious than in older women, and the high pressure is usually a better indication of impending toxemia than is the presence of albumin. More than 25 per cent. of women have albuminuria at some time during normal pregnancy and albumin may be present over comparatively long periods of time, in measureable amount, without influencing the blood pressure range and without complicating the pregnancy. Moderately elevated blood pressure or the presence of albumin has little significance unless accompanied by headache, visual changes and other signs of toxemia. Numerous cases are reported in which the systolic pressure has reached 160 mm Hg. and yet the patient proceed to term and a normal delivery.

A gradual rise in systolic pressure is of less significance than a sudden elevation.

The presence of elevated blood pressure, signs of toxemia and even convulsions in one pregnancy does not necessarily indicate that the patient will react in a similar way to subsequent pregnancies, indeed it is thought that if one eclamptic attack is successfully weathered and the blood pressure returns to normal soon after delivery, the patient thereby acquires an immunity to the toxic substances and is protected from a recurrence in subsequent pregnancies. In support of this Slemons, in 1917, studying 52 patients with toxic symptoms during pregnancy separated them clinically into three groups: (1) systolic pressure returning to normal two weeks after delivery; 75 per cent. of these had convulsions, but passed through their second pregnancy without evidences of toxemia; (2) the elevated systolic pressure remaining for more than six weeks after delivery. 10 per cent. in his series

showed permanent kidney damage and 7 per cent. of these subsequently required interruption on account of nephritis; (3) slightly elevated systolic pressure at the end of 30 days, 15 per cent. Here the diagnosis was doubtful as to permanent kidney damage, and the ultimate prognosis good in 85 per cent.

The systolic elevation does not necessarily parallel the degree of kidney insufficiency. The presence of edema bears no relation to the blood pressure level. The presence of acidosis occurring in pernicious vomiting tends to cause a fall in systolic pressure. The highest pressure I have found recorded in toxemia pregnancy is 250 mm systolic and the lowest 80. The systolic pressure shows certain characteristic variations during pregnancy, being slightly higher in the early months, falling somewhat in the middle and rising again towards the end of the gestation period. Systolic pressures may go to 150 and the patient have a normal delivery at term. The diastolic pressure is somewhat elevated in eclampsia and the pulse pressure always increased. Treatment of eclampsia when successful is accompanied by a reduction in systolic pressure. The occasional exception is met in shock and hemorrhage.

Aortic Insufficiency.—The general belief that a slightly elevated systolic pressure, accompanied by a pulse pressure approaching 100 mm Hg., even in the absence of a murmur or of cardiac enlargement, in pathognomonic of aortic insufficiency, must, in the light of unquestionable evidence be qualified by accepting the clinical fact that some cases of generalized arteriosclerosis, without demonstrable aortic incompetence, and an occasional case of hyperthyroidism, may present blood pressure findings very similar to that of true aortic incompetence. The valve of the arm and leg difference as an aid in the diagnosis of this disease has been seriously impaired by the studies of a large number of cases of aortic insufficiency by O. K. Williamson who concludes that higher leg than arm pressures are not the result of the valvular defect but are produced by hypertonic contraction and muscular-coat hypertrophy, with or without sclerotic change. He also states that the difference, when found, may be abolished by repeated observations, and cites 24 cases of undoubted aortic in-

sufficiency in 10 of whom the arm pressure was equal to or higher than the leg pressure.

Hyperthyroidism.—Blood pressure alterations in over activity of the thyroid and the effect of operative procedures in this disease have been carefully studied. It is of interest to note that the blood pressure changes seen in some cases of thyroid hyperactivity are very similar to those noted in aortic insufficiency, i. e., the systolic pressure is usually somewhat above the average normal, while the diastolic pressure is depressed, the result is an increased pulse pressure. Taussig calls attention to an additional similarity in that the leg pressure may be from 20 to 55 mm. higher than in the arm, and considers this point, in the absence of aortic insufficiency, a valuable sign in differentiating toxic from non-toxic thyroid enlargements.

Reisman has followed the course of the systolic pressure throughout this disease and finds that in the early stages the systolic pressure is usually lowered, through increased thyroid activity; during the acute stages the elevation of systolic is due to the combined action of adrenal stimulation and cardiac hypertrophy, while in the final stages systolic pressure tends downward through progressive myocardial weakness.

In drawing inferences from the blood pressure findings in hyperthyroidism, it would appear that the stage of the disease influences the pressure and that the presence of a large pulse pressure accompanying a slightly elevated systolic is indicative of an active progressive process. It is rather interesting to note that available reports of operative removal of varying amounts of the gland, while relieving the cardiac symptoms fail to have any appreciable effect upon the blood pressure, so it must be concluded that while the reduction of excessive thyroid secretion may arrest and reduce the cardiac and ocular phenomena, it fails to affect the permanent damage already done to the cardio-vascular system.

Auricular Fibrillation.—As would be expected profound alterations in rhythm usually reduce cardiac output with a consequent reduction in the pre-existing systolic level. The degree of fibrillation roughly determines the extent of systolic level, although no relation has yet been established between the onset of

fibrillation and changes in systolic pressure. In cases showing recurrent fibrillation, the coincident cardio-renal changes tend to elevate the systolic which, under close observation, will frequently be found to fluctuate rapidly between 140 and 200 mm Hg. Probably the greatest value of sphygmomanometry in auricular flutter, fibrillation and allied conditions, is its ability to demonstrate slight changes in force and rhythm of the pulse which may not be detected by auscultation of the heart or palpation of the radials.

Miscellaneous Conditions: (1) Albumin of Bence-Jones.—The systolic blood pressure is elevated to about 180 mm Hg., the diastolic to 100 mm Hg., the pulse pressure approximately 80 mm Hg.

(2) Amyloid Disease of the Kidney.—In spite of the usual association of chronic nephritis, the systolic pressure in the 15 cases reported was at or below normal in all but one.

(3) Angina Pectoris.—No special information is derived from blood pressure examinations made in this condition, for while the systolic pressure is variable the actual changes are slight.

(4) Arthritis.—There appears to be a peculiar relation between blood pressure changes and arthritis associated with Herberden's nodes. The average systolic pressure in 70 cases reported was 182 mm Hg.

(5) Acute Infections.—During the invasion, the systolic pressure is elevated. In robust persons the pulse pressure is large. During the course of the disease where recovery takes place, the pressures tend to regain their normal levels, whereas, a low systolic and a high diastolic with a consequent small pulse pressure is of bad omen.

(6) Dilatation of the Arch of the Aorta.—This is believed by Kilgore and Smith to be present in all cases showing large pulse pressures irrespective of its origin and is considered to be a compensatory process whose function is to relieve the arterial tree of some of the shock of an increased cardiac output. From my own observations, I believe this to be true and have systematically reported this finding, when a definite impulse could be felt on the supra-sternal notch. This finding can easily be verified by x-ray.

(7) Plural Effusion and Pneumothorax.—Williamson reports low systolic pres-

sure in the leg as compared with the arm pressure on the same side, the difference amounting to 10 to 20 or more mm Hg. It was present in 5 out of 6 cases of pneumo-thorax, the average dif-

ference being 16.5 mm Hg. and the greatest 27 mm Hg. It was present in 5 out of 7 cases of effusion, the average difference being 12.5 mm Hg. and the greatest 35 mm Hg.

Comparative Table, Showing Average Systolic Pressures and Variations by Five-Year Periods.

| Ages. | Fisher. | Woley. | | Faught. | |
|-------|----------|----------|-------------|----------|------------|
| | Average. | Average. | Variation. | Average. | Variation. |
| 15 | | 119.0 | 100.6—140.1 | | |
| 20 | 119.85 | 120.3 | 101.2—141.0 | 120.0 | 105—135 |
| 25 | 122.76 | 123.0 | | 122.5 | |
| 30 | 123.65 | 125.0 | 105.4—142.3 | 125.0 | 110—140 |
| 35 | 123.74 | 127.0 | | 127.5 | |
| 40 | 126.96 | 128.5 | 110.0—144.6 | 130.0 | 115—145 |
| 45 | 128.54 | 130.0 | | 132.5 | |
| 50 | 130.57 | 131.0 | 114.0—147.5 | 135.0 | 120—150 |
| 55 | 132.13 | 132.0 | | 137.5 | |
| 60 | 134.76 | 133.0 | 116.2—150.5 | 140.0 | 125—155 |

CHEST SURGERY*

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The abdomen for many years resisted surgical advance on account of the dire results following infection. When antisepsis and asepsis were developed, the abdomen yielded. Intrathoracic surgery continued to be an extra hazardous procedure, although the most wonderful advances were made in abdominal surgery. This was due mainly to the dangers associated with open pneumothorax. Unfortunately the teaching has been and still is that the mediastinum is a fixed, unyielding, almost rigid partition, completely separating one lung from the other. This in turn has given rise to the assumption that if one lung is collapsed the other will carry on the respiration. We read in the literature on open pneumothorax of "the sound lung, the healthy lung and the unaffected lung," when what is meant, is the lung in the unopened pleural cavity.

Graham and Bell¹, in 1918, by a series of experiments on cadavers (human and canine), showed that by injecting air in one pleural cavity to a positive pressure of 10 cm. of water the opposite pleural cavity registered a positive pressure of 9 cm. or better. In other words, the injected and uninjected cavities approached the same pressure. They made further experiments on living dogs, rabbits and cats substantiating this. They also showed on a mathe-

matical basis that the healthy adult without pneumonia and good respiratory muscles should be able to stand for a short time without death an opening in the throat of about 51.5 square cm. (5x10 cm.) (2x4 inches). They say: "It should be emphasized that, on the basis of our calculations, this is the largest possible opening compatible with life in the average healthy adult, with a normal mediastinum, and that life can be maintained with so large an opening for only a short time. It is larger, however, than the usual area of an opening in the chest, when an operation is made on the lung, especially when the opening is partly closed by the presence in the incision of a hand, the lung, a gauze pad or a number of instruments. There is, therefore, no discrepancy between the deductions drawn from our experiments and the clinical observations on war wounds of the chest."

These experiments take into account only changes in respiration and air content of the lungs, as induced by open pneumothorax, but there are other results. Sauerbruch², in unanaesthetised rabbits, in which he established an open pneumothorax at a room temperature of 20° to 22°c, the body temperature in some dropped 3½°c. in forty-five minutes. In dogs it dropped as much as 2°c. in thirty minutes and rose again 1.6°c. in one hour, after closing the opening. He also made observations that heat loss in open pneumothorax is greater than in extensive laparotomy, with evn-tration of the intestines for the same length of time. The danger of infection is also very great, since bacteria may so rapidly

*Read in a symposium on "Surgery of the Chest," at the Academy of Medicine of Northern New Jersey, November 28, 1922.

be aspirated and the power of walling off in the pleural cavity is nil.

Marked disturbances in circulation occur. Sauerbruch states that in pneumothorax, the aspiration of the heart fails. A stasis of the venous system occurs. Measurement of the venous pressure in the femoral gives an increase of pressure. There is no marked change in arterial pressure. Until asphyxia occurs, when there is evident a rise in the carotid pressure. To this is added the well-known mediastinal flapping or flutter, due to the to and fro motion of the mediastinum in open pneumothorax during respiration. To obviate the above conditions, two main methods have been employed. One: To open the pleura, with the operator and the patient's body in a negative pressure chamber. In the other, to have patient's head in a positive pressure cabinet. The latter method has been simplified as follows: Positive pressure is maintained by intrapharyngeal insufflation. Catheters are passed through the nares, as usual, and when the positive pressure is needed the anesthetist by a hand, foot or machine pump supplies it, meanwhile holding the patient's mouth tightly shut. Many surgeons maintain that intrathoracic surgery can be performed without recourse to any of the above measures.

This is quite true when the pleura is adherent or the mediastinum stiffened by inflammatory reaction and when the opening is smaller than 51.5 square cm. The results of the experiments, however, by Sauerbruch, Graham, Bell and others, I feel, should lead us to employ every method to overcome the effects of open pneumothorax and the simplest way that this can be done is by the intrapharyngeal insufflation method. The choice of the anesthetic depends largely on the patient's condition and the lesion for which the operation is performed. Local anesthesia, nitrous oxide and chloroform are all used by various authorities. Ether, on account of local irritation, is least employed.

I do not believe that this symposium was intended to include lesions of the chest wall, so I have omitted them and will begin with the much-discussed treatment of empyema. The literature is voluminous and the advocates of the open and closed methods are just as unyielding as are the irrigators and the non-irrigators, some with and some without negative pressure. It really seems quite hopeless, but analyzed to the fundamental principals it is rather

simple. In the first place, differentiate between empyema and pleritis. Pleritis without frank pus should be treated by aspiration or a closed method. Irrigation if you like. I do not. Negative pressure if you wish. I think its value is doubtful. Now as regards real pus in the pleural cavity. No doubt many are treated and cured by a closed method, sterilizing irrigation and negative pressure. I, however, prefer, when pus is true pus and adhesions have fixed the mediastinum and pleura and there is no pneumonia, to resect a rib. This is a simple procedure, under local anesthesia, even in children, and I feel confident that I will at a later date be able to show that empyemata can be cured more rapidly by rib resection, without irrigation or negative pressure, than by any other method. One must remember, however, that rib resection, in other words open pneumothorax, is deadly, when there is still a pneumonia present and no pleura or mediastinal fixation. The length of time from the onset of the pneumonia, the temperature, the physical signs, character of aspired pus, x-ray, etc., will tell when to resect a rib.

For intrathoracic procedures there are three main avenues of approach.

1. Single rib resection to a greater or less extent. This gives a limited exposure and a small field through which to manipulate.

2. Trap-door incision, with which you are all familiar. Several ribs are divided with overlying soft parts turned out, giving fair exposure and field of approach.

3. The exploratory thoracotomy incision—a long incision in the sixth or seventh interspace, usually beginning at the angle of the rib and extending well forward to the anterior axillary line. A rib spreader can be inserted and an excellent view and opportunity for manipulation gained. If necessary one or more ribs are divided posteriorly to gain additional space. Then there are also the various sternal splitting procedures, which are, however, rarely necessary.

Injuries.—Chest wall injuries and fractured ribs uncomplicated, everyone has treated. Hemothorax is usually best when not interfered with. The blood will absorb as a rule. When absorption is slow, the blood may be aspirated. If infection supervenes drainage is indicated. If bleeding continues and general symptoms of hemorrhage present an exploratory thoracotomy must be performed and the

bleeding controlled. Penetrating wounds must be judged individually. Symptoms of hemorrhage indicate exploratory thoracotomy, with suture of the lung, heart, etc. Remember the anatomy of the lobes, two entrance and two exit wounds, a pair in the upper and a pair in the lower lobe are not exceptional. Large so-called sucking wounds of the chest demand immediate suture, after thorough revision of the wound, injured organs and removal of debris.

Foreign Bodies.—Here the bronchoscope is most important as all know. In fact, bronchoscopy is very important in all chest work, both diagnostically and therapeutically, and should always be called into use. The same is true of x-ray. I will not say any more concerning these two specialties, as the time is short, but I know you all appreciate their immense value in this work. Some foreign bodies, such as projectiles, cannot be reached through the bronchi. Here careful x-ray localization is essential—then exploratory thoracotomy—lung palpation, affected portion dragged out of wound and foreign body extracted. It is important to remember that the foreign body will change its position to a marked degree, when the pleuracavity is opened and the lung collapsed.

Dr. Petit de la Villieon has a most novel method. Quoting from 'Moynihan', in the British Journal of Surgery: "The operation consists in the introduction, through a very small incision made between two ribs, of a special pair of forceps, with a blunt end and long, parallel blades on the one side of the hinge, and short 'crocodile-jaw' blades on the other. The position of the foreign body is very accurately determined by the x-ray. The operation is performed under the x-ray and with the aid of the screen. A preliminary injection of morphine is given and a light general anesthesia induced. Petit de la Villeon uses chloroform. The forceps are introduced from the axillary side, the incision to admit them being made along the upper border of the rib, so as to avoid vessels, and are guided by the image on the screen and directed toward the known position of the foreign body. The process of the instrument is slow and gentle and continues until the image of the tip of the forceps and of the foreign body coincide. If the entry has been expertly made, the contact will then be felt; the metal is grasped by the wide opening of the 'crocodile-jaw' blades, and is slowly and steadily withdrawn. Nothing

remains but to close the skin wound by a single stitch. The penetration of a blunt forceps into the lung tissue does no damage. It ruptures no vessels; it does no injury to the delicate tissues of the lung; it seems to cause a separation of the tissues rather than a destruction of them. The experience of recent wounds of the lungs in this war has shown how very tolerant to injury they are and how few are the symptoms produced by the slighter degrees of trauma. It is not then surprising to hear that a blunt instrument may be gently pushed through the lung substance without giving rise to any real danger. The withdrawal of a foreign body might be attended by more serious injury, especially if there were many sharp points and rough surfaces; these, however, do not inflict much injury, if any, if the jaws of the forceps grasp and include the foreign body in their embrace. Such damage as is caused would be enhanced in severity if the metal chanced to be infected by one or more organisms, which we know will remain potentially active in the lungs for years. But suppositions and fear must yield to experience, and this has given abundant proof, in the hands of all, that the risk of injury is almost negligible. The mortality has been found to be extremely small, far less than by any other operation practiced. The post-operative course is so smooth and devoid of incident, as to excite the frank astonishment of all who see the method practiced for the first time. The functional recovery is said to be at least as good as that which follows the open operations; and is obtained at less risk and less cost in respect to suffering and duration of convalescence."

It has, however, been found to be a hazardous method, when the missile lies in the root of the lung. Here Petit de la Villeon proceeds, as follows, again quoting from Moynihan³: "An approach to the hilum from behind is advised by Petit de la Villeon (Bull et mem. Soc. de Chir., 1918, p. 976), who describes an area bounded on the inner side by the spine, on the outer by the border of the scapula, above by the fifth rib, and below by the eighth rib, as that in which the shadow of the root of the lung falls. If a piece of metal is seen in this area and is gauged to be at a depth of from six to thirteen cm. from the posterior surface, it lies in the root of the lung. His operation is practiced in three stages:

"Stage 1. Performed in a strong red-

orange light. The patient lies prone. Omovertebral space is opened and resection of the necessary ribs (sixth, seventh and eighth) is performed; the resection is made as wide as possible to give free access. The pleura is opened.

"Stage 2. Performed under x-ray, with screen examination. A long pair of forceps is passed through the visceral pleura and the lung to the hilum. Guided by the image on the screen, the forceps seizes the foreign body, grasps it, and is held steady.

"Stage 3. In daylight. The forceps is withdrawn with the projectile. Into the wound made by the forceps, the surgeon plunges his left index finger; this he gradually withdraws, packing guaze in long strips into the cavity it occupied. The wound in the parietes is closed. The packing remains for forty-eight hours, being loosened first by hydrogen peroxide. It is thought that the free pneumothorax aids in haemotaxis. Sixteen cases are recorded, with sixteen recoveries. In none was there any hemorrhage."

I quote these procedures as a matter of interest. No one else, to my knowledge, has ever attempted them.

Lung Abscess.—These conditions are becoming more frequent, and are the dreaded complication following nose, throat and mouth operations. Many lung abscesses heal spontaneously. In all cases careful roentgen and bronchoscopic examinations should be employed, as routine measures. Foreign bodies may be the etiologic factor and removal establish a cure. Intratracheal and intrabronchial washings, through the bronchoscope, may cause amelioration. Postural drainage should be given a thorough trial. The chest should not be opened until all other measures fail. The average length of time between the onset of symptoms and operative intervention, in Lilienthal's⁴ cases, is one year. Experience may show that early operation gives better results, but this remains to be proven. In parenchymatous abscesses, opening and drainage can cure. In bronchiectatic abscesses, lobectomy is the only procedure that really gives good results. Other procedures are artificial pneumothorax, pneumolysis and various thoracoplastics.

Tumors.—These are chest wall, pleural, lung and mediastinal (which includes esophageal). Chest wall tumors are removed by block excision of tumor bearing area, soft parts and ribs. This causes a pneumothorax and the lung must be re-expanded, with the defect closed airtight.

This may tax the ingenuity of the surgeon. Pleural tumors should receive similar treatment. An exploratory thoracotomy may first be performed and the subsequent procedure based on the findings.

Lung Tumors.—Small endotheliomata of the bronchi have been removed endoscopically. The whole question is, however, very disappointing. Very few recoveries have been reported. The procedure—careful roentgen localization—bronchoscopy and exploratory thoracotomy. If the tumor is found operable it is excised and the lung tissue carefully ligated and sutured, endeavoring to prevent bronchial fistula. The chest is closed tight. A two-stage operation is often preferable. Mediastinal tumors are usual diagnosed too late to be surgically removable. To relieve pressure symptoms the sternum may be split transversally or longitudinally or the costo-cartilages cut at their sternal ends.

Esophageal Tumors.—Not only must the tumor be removed, but the continuity must be restored. The great danger lies in mediastinal infection. Lilienthal⁵ has lately developed a procedure whereby he makes an approach through the posterior mediastinum and forms a skin tube to replace the defect, after removal of the growth. This is done in several stages.

Bronchiectasis.—Bronchiectasis is treated surgically by artificial pneumothorax, chest collapse and lobectomy. The latter is feasible only when but a single lobe is involved.

Tuberculosis.—The artificial pneumothorax treatment of tuberculosis is well-known. In a certain number of cases it is a failure, because of pleural adhesions. Sauerbruch⁶ has devised a procedure to be used when artificial pneumothorax fails. The indications must be very carefully weighed, as the procedure is a grave one. All other measures of treatment must be tried and found wanting. Briefly described, the operation consists of subperiosteal resection, without opening the pleura, of all the ribs, from the first to the ninth or tenth inclusive. This is done through a posterior incision, and about three-fourths to one inch is resected from the first, and the portion resected is increased with each succeeding rib, until finally six to seven inches are resected. The mortality is high, but the cases chosen are chronic invalids, with no hope of recovery, and some of the results have been remarkable.

This has been a sketchy resume of chest surgery, and a number of procedures have been omitted, among these are cardiolysis,

lung decordication, the various collapse operations, cardiac suture, Freunds' operation for emphysema, due to ossification of the costo cartilages, etc. To include all of these would keep us here indefinitely, and I am sure you will feel relieved to know that I have finished.

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ADDRESS OF PRESIDENT OF ESSEX COUNTY SOCIETY.*

By Francis R. Haussling, M. D.,

Newark, N. J.

With the completion of the 107th year of this society's life history, it seems fitting to retrospect with some degree of pride. At the same time we must avoid the dangerous attitude of self-sufficiency. When I first became a member some eighteen years ago, our meetings and activities were of an entirely different character from what they are today. This has been brought about in a large measure by the change in the nature of the times.

At that time the meetings were in a large measure scientific in character, devoted to the reading of scientific medical essays by eminent physicians from other cities. The presidential address almost invariably took up for consideration some medical subject, intended to educate the medical profession, but not intended for the laity. These meetings were both interesting and beneficial to the physicians. They would probably still be in vogue were it not for the fact that the necessity for the scientific education of the physician

has been relegated somewhat into the background by the more urgent need for the education of the general public in health and medico-legal questions. This has been due to the harmful activities of a multitude of cults, Socialists and self-seeking or misinformed politicians. The need for this political activity on our part was brought to a crisis some three years ago by the passage of the chiropractic bill by the New Jersey State Legislature at Trenton. This bill was such a distinct and unmistakable step backward, from the standpoint of educational standards, that it became self-evident in order to protect and educate the general public some concentrated action must be taken. The physicians being the logical leaders in health matters, it became our duty to assume this responsibility.

The Welfare Committee of the State Society early realized that to accomplish anything at all it would be necessary to have the hearty and undivided co-operation of the component county societies. This support was promptly pledged by our society as a whole and further augmented by the individual members, as shown by their frequent pilgrimages in large numbers to Trenton during the session of the State Legislature.

It can safely be stated without fear of contradiction that these efforts by the medical profession were not inspired by any selfish motive, but were entirely in the interests of the general public health. It was an effort to maintain the high educational standards required of those who practiced the healing art. It had taken thirty years to build these standards, which were shattered by the passage, the year before, of a single bill. This bill created a State Board of Chiropractors, with power to license individuals to practice chiropractics, who had practically no preliminary education, even of a general character. It amounted to this. If this board saw fit it had the legal power to license a man to practice on the basis of a six weeks' correspondence course, who had not spent a day in high school. It should be easy for any layman without knowledge of health matters, even though he be a firm believer in one of the healing cults, to see that such a state of affairs would be more of a menace to the general public than to the physician. Although this bill was passed during the 1919-1920 session of the Legislature and was made void by the passage of Senate bill No. 149 in 1920-1921, both of

*Presented at the annual meeting of the Essex County Medical Society, October, 1923.

which facts are well known to you, I again bring them to your attention, for during 1921-1922 a strong effort was made to break down educational standards. And the end is not yet, unless we are eternally vigilant. The best way to combat this menace is to educate the public. To tell our patients at every opportunity just what we desire of the practitioners of the cults. That they shall be high school graduates and shall be further qualified under recognized requirements.

Having so qualified they shall be granted a limited license to practice the form of treatment for which they are fitted.

Until we have convinced the public that our attitude is truly unselfish and entirely in their interests, we have got to wage this same battle from time to time.

Although I believe we are in politics to stay, we must be very careful to refrain from any pernicious activity and must at all times restrict our efforts to such matters only as effect the public health. This surely covers legislation affecting the management of the rehabilitation work in the State, the management of the State medical institutions and even the question of establishing maximum and minimum fees in connection with the operation of the new medical amendment to the Workmen's Compensation law, passed at the last session of the Legislature.

This society, as you all remember, was unalterably opposed to the establishment of maximum and minimum fees. Why should physicians be bound by a schedule. In private practice medical fees are based upon the usual fee prevailing in the community. Why should a physician charge more or less for individuals of a given financial standing than he would were the workman paying his own way. Why should the insurance carrier receive special consideration at the expense of the physician, and the injured workman. We advocate, firstly, that the compensation paid to the injured workman shall be more liberal. He now receives \$12 a week for the support of himself and family, while temporarily incapacitated. Secondly, we advocate that the medical treatment and care shall be adequately compensated and that the decision as to what constitutes adequate compensation be placed in the hands of physicians of standing and not in the hands of laymen, as it is at present. In the event of a dispute in a given case, as to the fairness of the charge, the county medical society, through committee, should

decide the usual fee prevailing in that community for a patient in the same financial circumstances. This could be easily and would surely be justly established, for, while a few physicians may attempt to impose upon the carrier, the large majority are fair and honest in their dealings. This holds true of any line of endeavor.

We were unsuccessful in our opposition to Assembly bills Nos. 64, 65 and 66. The passage of these bills removed the boards of managers from Soho and Verona and were passed on the plea of greater efficiency by placing the chosen board of freeholders in more direct control. Our opposition to this state of affairs is not unique.

The National Tuberculosis Association advocates the appointment of boards of managers in all sanitorias taking care of tuberculosis patients as the only barrier to protect the patients against political changes and pernicious political activity. This defeat again demonstrates that the only argument worthwhile, when dealing with the politician, is unity of purpose, supported by voting strength. Perhaps the politician should not be blamed too much for this attitude. How else is he to know what the majority of his constituents desire. And, naturally he wishes to be returned at the next election.

In Essex county at the last election there were twelve Assembly candidates. We opposed four of these. The eight unopposed averaged 44,787 votes, the four opposed averaged 42,552 votes, a difference of 2,235 votes. There was no other interest opposed to all four of these candidates, therefore, this difference was the strength of the medical opposition. One failed of re-election by 888 votes. Our opposition was sufficient to defeat her. This is the only effective argument at Trenton. So much for our activities in the interest of the public health.

In my capacity as president of your society during the past year, it has been forcibly brought to my notice that all is not as it should be in our relations to one another. There have been complaints of unethical action made by both physicians and laymen against physicians, members of this society. Not of a criminal nature, but still serious enough to warrant some action on the part of this society if we are to maintain our ethical standards. In the first place, these standards should be more clearly defined, and, secondly, members of the society should be made to live up to

them. The younger physician asks, and rightfully so, why should he live up to the dictum of the golden rule, when older members of the society retain their membership without doing so.

It has occurred to me that we should have a committee, called either the grievance or ethics committee, patterned somewhat after the fashion of the ethics committee of the Lawyers' Club in Essex County. It is true that at present these grievances, both great and small, may be referred to the council. The council, as a matter of fact, hasn't the time nor machinery to handle these cases properly, nor have its findings sufficient weight. Why not have a committee whose sole duty it shall be to consider charges of unethical action of a non-criminal nature.

The following is the method of procedure in this class of cases among the lawyers:

There is here in Essex county the Lawyers' Club, which is a membership corporation, having certain characteristics akin to those of an ordinary club, but in addition, through committees made up of members, it performs various public duties, which, while not authoritative, nevertheless, are a public benefit. There is among the committees one known as the ethics committee, which deals with infractions of law or ethics, by members of the profession.

Briefly, the practice in such cases is as follows: If a lawyer has been derelict or unethical in his duty, or some one thinks he has, the party injured by the lawyer's acts or who knows of them, will take the matter up with some other lawyer, a judge, the district attorney, or the Legal Aid Society, who in turn will advise laying the facts before the ethics committee. This committee takes the matter up and questions the complainant carefully, gets his whole story, sends for the accused lawyer, obtains his version and in some cases hears other witnesses. The ethics committee considers it and votes as to whether or not there seems to be any real foundation for the complaint. If it decides there is not, it dismisses the case. If it decides there is, it reprimands the offending lawyer. Although these findings have no binding effect and are more or less in the nature of an expression of an opinion, still they are so influential that the offending lawyer almost invariably refrains from repeating the offense. And here is the crux of the situation. Were he to do so, he would be practically ostracized by his fellow lawyers.

The reprimand acts as a deterrent, inasmuch as the legal profession gives its moral support to these findings. This holds good whether or not the guilty lawyer is a member of the society.

The practice followed as above outlined could be easily applied to the medical profession. A committee similar to the ethics committee could hear both the complainant and the defense, with witnesses. If the charges were purely of an ethical nature the ethics committee could have power to act or could render its decision to the society for final action. If they were of a criminal nature or involved the revocation of the license to practice, its decision could be referred finally to the State Board of Medical Examiners, who are now legally qualified to prosecute without trial by lay jury. (Senate bill No. 113, 1921.).

You may say that the council can do all this. Perhaps it can, but, from personal experience, I say that if that is so the council has been derelict in its performance of duty. Has not the time come to handle these cases properly and to have its findings sufficiently influential to carry the necessary force. The standard of ethics in the medical profession today is an unknown quantity. The individual physician sets his own standard.

In closing, I take this opportunity to thank the society for the honor conferred upon me. If I have failed to live up to the expectations of the individual members it is because of my inherent limitations.

SOME CONTEMPORARY ASPECTS OF MEDICAL ETHICS.

Presidential Address at the Annual Meeting of
the Passaic County Medical Society,
October 11, 1922.

By Elias J. Marsh, M. D.,

Paterson, N. J.

It is customary for an outgoing administration to "point with pride" to its record of achievements, as well as to give wise(?) counsel to its successors. I have no very brilliant record to point to, but I desire to advert to our latest achievement, viz.: the publication of the constitution and by-laws of the society, which have long been out of print. A copy has been sent to every member, and now all may know the rights and duties of membership.

More especially I desire to point out two sections of the by-laws for consider-

ation this evening. The first of these is Sec. 1 of Chap. IX, which says: The Principles of Medical Ethics of the American Medical Association shall govern this society." The "principles" referred to are contained in a little booklet, copies of which were supplied to the members of the society some years ago, but which I am afraid many of the more recent members have never seen. We are now arranging to provide every member with a copy of the last edition of this book also.

The Principle of Medical Ethics herein set forth are the present-day expression of that feeling of professional obligation and esprit du corps which has marked the medical profession from its first appearance in the dawn of history. One of its earliest known formulations is contained in that famous Hippocratic Oath which, after three thousand years, we still take at our graduation as Doctors of Medicine. The tradition of a code of professional etiquette was in formen times, down to a day still remembered by the older members of our own society, inspired in the medical student, with the rest of his professional training, by his preceptor, in closer association with whom in his practice he received his initiation into the mysteries of medicine. With the passing of the preceptorial system, and the substitution therefor of intensive clinical teachings in the medical college and hospitals, the intimate human contact, and the resulting sense of fellowship in a brotherhood of physicians, was largely lost. And with the increased opportunities for the study of medicine, many men entered the medical colleges who had not the professional instinct or idea, but looked upon medicine merely as a trade, to be conducted in the spirit of trade competition. Hence the necessity for the definite formation of the traditional ethical spirit of the profession.

Examination of our booklet shows the Principles to be grouped in three main divisions, corresponding to the three relations of a professional man's life. First in order, as in importance, is his obligation to his patients: this, as every physician knows, must come before any other consideration whatsoever. Next is his obligation to his professional brethren and third, that to the whole community in which he lives. Not till all of these have been fulfilled, may the true disciple

of Hippocrates and Galen, of Servetus and Pare, of Jenner, Rush, Lister and Walter Reed, think of himself.

It is not my purpose to discuss these obligations tonight: they are already familiar to you all. But I wish to direct attention to certain applications of them that are of immediate and increasing contemporary interest. One arises out of the prevailing practice of bringing suits for damages against physicians or surgeons, the result of whose management of a case are not what the patient or his friends think it should be. Many of these suits are strike cases pure and simple, brought in the hope that the defendant surgeon will settle for a moderate amount, rather than face the notoriety of a trial, or the uncertain hazards of a jury verdict; some are brought in good faith at the instigation of friends or the suggestion of an attorney; a few have real merit. To these last, valid objection can not be made.

It is the unfair suits—some of them plain blackmail—that gives occasion for these remarks. Few of these could have any hope of success without the assistance of medical men who can be found to testify against their professional brethren in a manner directly contrary to, the spirit, if not the letter, of professional ethich. Again, strike suits would greatly diminish if none were compromised but every such suit was defended to the legal limit, for it may safely be said that cases of this character would have small chance of success on appeal. Therefore, for any physician to compromise a suit to save himself, unless ready to admit that he is at fault and so fairly liable, is unfair to his colleagues as encouraging similar suits, and should be regarded as unprofessional conduct. The situation is familiar to you all, it has been generally discussed in medical circles, and I bring it up here to endorse two suggestions that have been made: first, that any physician who shall give evidence against another in a case of this character, save as to matters of fact when under subpoena, shall be liable to a charge of unprofessional conduct; and second, that no member may settle such a suit, without the consent of the Board of Censors, or of the Judicial Council, but must fight the case to a finish. In this connection I wish to speak of the new group-insurance contract which has been arranged by the

State Society, which provides that the insured shall have the moral support of the society and its members. This, of course, includes the matter of testifying at trials. I believe that this is the most important professional matter now before us, and earnestly commend it to you not for consideration only, but for action.

The second section of the by-laws to which I wish to refer, very briefly, for the information of those who may have overlooked it, is the seventh of Chap. II. which, in presenting the duties of the Board of Censors, says: "Any member . . . may submit to them for opinion and advice any question of professional ethics or conduct, or to ask their assistance and good offices in settling any difficulty which he may have with any other physician."

To return for a moment to the Principles of Ethics and to the third chapter thereof: the first two sections relate to public hygiene and the duty of enlightening the public on sanitary matters. Two propositions now before the Paterson Board of Health will shortly be brought before this society for its consideration. Ample opportunity for discussion will be afforded, but if the society once takes a position in regard to these or any other cases, every member should consider himself bound to aid in educating the public to their value, or if he cannot conscientiously do that, he should at least be silent, and on no account openly oppose the expressed opinion of the profession, as represented in this society.

One more brief word, and I have done. It is every physician's duty to his patients, the first of all his duties, in case of consultation, etc., to secure the best professional assistance that he can obtain. I wish, however, to say a word in favor of those of our own brethren who are trying to do in our own communities the best clinical and scientific work that can be done, and then are forced to face the competition of advertising commercial laboratories, chemical, radiological, etc., in New York, Newark, and elsewhere. If you feel that such places can do the most for your patients, well and good, otherwise let us remember the brethren of our household.

Gentlemen, I thank you for your attention and for the honor you have done me in choosing me for your president during the past year.

TUBERCULOSIS LEAGUE PROGRAM FOR MIDDLESEX COUNTY.

By Charles I. Silk, M. D.,

President of the Middlesex County League, in
His Address at the Annual Meeting, Held
in Perth Amboy, January 5, 1923.

Perth Amboy, N. J.

Ladies and Gentlemen: Tuberculosis Workers in Middlesex County and Honored Guests—In behalf of the Middlesex County Tuberculosis League, I wish to extend to you all a most hearty welcome and the season's greetings. The purpose of this meeting is to bring the workers in closer touch with each other as well as with the work of the organization as a whole.

It is customary on such occasions to review the past year's accomplishments and to propose an outline of the work contemplated for the following year. Since the executive secretary has prepared a detailed, typewritten report of the past year's activities, which you may read at your leisure, I will proceed with the program for our future consideration. Almost every tuberculosis worker at some time or other feels that he has an ideal solution for the tuberculosis problem, and I am no exception to the rule. The number of such ideal plans is legion. The only trouble with these plans is that they are too idealistic, all-inclusive and impossible of materialization. I hope that I do not commit the same error in presenting my plans.

Clinic and Nursing Service.—The first and foremost requirements for a successful plan is a clinic properly equipped with a full-time expert examiner and an adequate nursing service. The clinic is the first agency that comes in contact with the patient and stands between him and the sanatorium. It must serve as a clearing house for all cases discovered, whether they enter a sanatorium or not, so as to have an easily accessible record of all cases. The clinic should have an x-ray apparatus and means for laryngeal examination. In England they estimate one full-time examiner for every 150,000 to 200,000 population in the more congested districts—one nurse for every 100 positive sputum cases, for the first 300, and one nurse for every 150 after that. This proportion of nurses would suffice for finding, as well as for following up cases.

Hospitals.—The sanatorium problem would be greatly facilitated if we could educate the authorities and interested parties (hospital superintendents, doctors, mem-

bers of hospital boards, freeholders, etc.) to the point that they may be persuaded to build tuberculosis wards in connection with the existing general hospitals. There are but few of us, indeed, who realize the far-reaching effects of such action. The first of these is economy. It would cost much less to build and maintain a ward or two in connection with an existing hospital than if such accommodation had to be provided for separately and was removed from the larger centers of population. Second, it would serve as an educational means, for both doctors and nurses to learn about tuberculosis, its diagnosis, prevention and treatment, as well as the best methods of chest examination. This would also be of inestimable value in overcoming the prevalent phthisiophobia. Third, such wards could be used for the advanced cases, who should not be sent far away from their homes, the main purpose being isolation, for the benefit of children and others at home. Another use of these wards would be for observation of suspected cases until their diagnosis is established. All this would go far towards relieving the county sanatorium, which should be used chiefly for the more hopeful and early cases. Middlesex County has three large general hospitals. If each were to build wards to take care of about twenty-five or thirty patients, together they could accommodate from seventy-five to ninety patients. The maintenance of these wards would be assured, because they would receive compensation from the freeholders at the same rate that is now being paid to outside sanatoria, which is \$18 per week, per patient. Under such conditions, a county hospital accommodating from 100 to 150 beds would take care of all of the present needs. Provision, however, should be made for the care and treatment of surgical tuberculosis, either in conjunction with the county sanatorium, or preferably in a separate institution, situated on the seashore. This department should be equipped to take care of bone, joint and glandular tuberculosis, with heliotherapy (natural sunshine, as well as artificial light), x-ray, tuberculin treatment and orthopedic appliances.

Definite attempt at examinations of large groups of people, e. g. industries.

Vocational training and industrial readjustment, for the arrested cases. This is a most difficult subject and far from being solved.

A definite program of nutrition for school and pre-school children. Until now this

phase of the work has received but scant and only haphazard attention.

Control of Milk Supply.—None but pasteurized or milk from tuberculin-tested herds should be permitted to be sold. This would eliminate from 15 to 25 per cent. of tuberculosis, which is of bovine origin, and accounts for the largest number of surgical cases.

To Summarize—The following items should be included in an adequate and well-rounded tuberculosis program for Middlesex County: (a) Clinic properly equipped, including x-ray apparatus; (b) Full-time expert examiner; (c) Adequate nursing service; (d) Tuberculosis wards, in connection with existing general hospitals, for advanced cases and observation of suspected cases; (e) County hospital for early and hopeful cases, including a preventorium; (f) A hospital on the seashore, for surgical tuberculosis; bone, joint and glandular tuberculosis; (g) Vocational training and industrial readjustment for arrested cases; (h) A definite program of nutrition for school and pre-school children; (i) Definite attempt at examinations of large groups of people, e. g. industries; (j) Control of milk supply.

This, then, is my plan for Middlesex County for the coming year, not that I expect it to be fulfilled within that period, but rather that I hope it may serve as a guide-line, feeling certain that if followed closely it must be productive of the best results.

THE FEEBLE-MINDED*

By E. R. Johnstone, M. D.

Director, Training School at Vineland, N. J.

I come before your body today more to ask for help than to tell you something. Whenever an institution man appears before such a body he is anxious that it shall carry to the people of the State more information about his particular problem. There are some very important things which we feel the citizens of the State should know, that can be best told them through such men as yourselves.

First, we ask you to let them know the distinction between insanity and feeble-mindedness. I shall not attempt to speak in scientific terms, but in the language that anyone may understand. We wish you to make it clear to them that the insane person is one who has at one time had a normal mind, which, because of illness or acci-

*Read at the annual meeting of the Cape May Medical Society.

dent or strain, is not functioning properly; that the feeble-minded person is one whose mind has never developed normally. Some forms of insanity are curable, and, perhaps, no State in America has had such striking results as our own. Feeble-mindedness, however, is a condition, and a truly feeble-minded person cannot be cured. He may be trained—the mind that he has may be developed sometimes to a surprising degree, but it cannot be brought to normality.

Again, let us make a distinction between feeble-mindedness and backwardness. Given proper care and training, the backward child will advance indefinitely—more slowly than the normal, perhaps, but still he can advance into the normal field. The feeble-minded person may make some improvement, but sooner or later he will come to his stopping place. If that comes early he belongs to the lowest group of the feeble-minded; if late—that is, if he may acquire a mental age of ten or twelve years—he will be among the higher group. For convenience, we divide all of the feeble-minded into three groups—idiots, imbeciles and morons. The idiot is the lowest. He does not achieve a mental age beyond that of the average three-year-old child. For all practical purposes he is helpless and hopeless. He is usually unclean in his toilet habits, speaks but little, or not at all; and, in extreme cases, may be of such low grade that if he has the sensation of hunger he might sit at a table on which there was food and yet starve to death, because of his inability to make the association between his hunger and the food.

The middle group are the imbeciles, with a mental age of that of normal children, between three and eight. They are the untable, tottering, unsteady group, as far as intellectual attainments are concerned. As they grow up with the minds of children and the bodies of men and women the community often expects much more of them than they can do, and they frequently get into trouble because of this. Occasionally the community recognizes them. Each of you probably know the simple individual who does the odd jobs of the community, but is looked upon as the plaything for the rougher element. This fellow frequently does wrong because he does not know any better, or thinks in his foolish mind that he can "fool the rest of the people."

The morons are the highest group, with a mental age of eight to perhaps twelve

years. Many of them are at large in the community today, holding jobs that require only the simplest intelligence, spending their time and money unwisely, and noted for doing "foolish" things. They seldom hold a job very long and their employers always look upon them as stupid and unreliable. If conditions of work are pleasant and they feel like it, they may go on steadily for a long time, but usually they change jobs often, with a careless indifference as to the future. They are often found in your homes as maids, and your wife wonders if she can ever get someone who won't break so many dishes or forget so many times, or do the most outlandish things under unusual circumstances. These are the people who quickly fail under sustained responsibility.

I should like to say a word at this point about sustained responsibility. When a tired business man or housewife comes to you all worn out with nerves frayed, you speak of it as a nervous breakdown. It usually means that this person has for too long a time carried a heavy burden of responsibility. In the same way a very much lighter burden of responsibility which the feeble-minded may carry for a while breaks them down that much sooner. A child in school may behave perfectly for five minutes, while the teacher is out of the room, but if this is required too frequently or if the five minutes is extended to a half-hour or more the responsibility of being quiet becomes too great. So it often happens that feeble-minded persons get a job which they hold very well for a while, but soon the sustaining of the responsibility is too great; and then they throw up their job, or lose their temper, or take tempting things, or in some way go to extremes, which may even amount to violation of the law. Here is where a better understanding of this class of people and a knowledge of just who they are would be valuable; and just as the tamer of wild animals is supposed to know a moment before the animal acts who it is about to do, so if we can understand the feeble-minded we may to a very large degree foretell what they will do under given circumstances.

It is the psychologist's job to interpret, the teacher's job to train to usefulness and the physician's job to discover how this condition may be prevented. In his efforts to interpret the psychologist has devised a number of classifications. First of all he took the old classification which we have all used in placing anyone we know; we speak of our children and our friends

and acquaintances as being exceptionally bright, or average, or dull or mentally deficient. Since the scientists got to work on this subject they have made a percentage classification, and they say that in any given State the people of that State may be divided into: 3 per cent. exceptionally bright, 12 per cent. bright, 70 per cent. average, 12 per cent. dull, 3 per cent. backward or feeble-minded. This is all right, as far as it goes, excepting that it does not give us accurate enough lines of demarcation and opinions play too large a part.

The next step was the devising of what is known as the measuring scale for intelligence or mental age. Tests have been devised which show the various levels. The average eight-year-old child can do certain things that the five-year-old cannot do, and the eight-year-old cannot do certain things that the eleven-year-old can do. If a child with a chronological age of eight can only do six-year tests, he is said to have a mental age of six and is retarded. If he does the ten-year tests he has a mental age of ten and is advanced. This scale is not perfect, but it is practical. Those who criticize it most are usually those who use it least. Just as you can ascertain with a yard-stick whether you have enough cloth to make a suit of clothes, so you can tell with the intelligence scale whether you have brains enough to pass a given school grade. But the yard-stick will not tell you whether your cloth is green or blue, rough or smooth, wool or cotton; neither will the intelligence scale tell you whether you are of stable or unstable mentality, or whether you are verbally, manually or socially-minded; it will not tell you whether you have been stupidly or wisely taught. It is primarily quantitative.

Mental age or intelligence level is a thing. We all have it and if we know it for those with whom we deal it explains many difficulties and offers many suggestions. For example; a ten-year-old with a mental age of five years may have reached his ultimate level. He will probably never get beyond the kindergarten grades. But he may learn a great many things on that level. The normal child goes up year by year from step to step. He has not time to learn all of the things on the eight-year step before he steps up to the nine. He actually does not learn them much better than 70 per cent. perfect (this is the passing rating in most schools) when he is advanced. The slow or defective child has more time, for he stays two or three or

more years on the same step, and so, perhaps, learns more, or better at that level than the normal. The normal climbs. The sub-normal spreads out.

Consider now the bright child: Actual age, ten; mental age, twelve. If he is kept in the fourth grade he does the work rapidly and has idle time on his hands. The wise instructor will find extra occupation for him, will enrich his curriculum, will give him a chance to spend some time with his special interests. The foolish instructor will endeavor to keep him down and will inadvertently teach him habits of idleness or laziness or misbehavior. Occasionally we find an exceptionally bright boy in the backward or truant groups, because his teacher didn't know his mental level, and he got tired fooling along waiting for the "stupids" to finish their regular tasks.

When the wise school men of Michigan had thoroughly tried out intelligence testing and classifying, according to the tests, they concluded that: All classes (bright, average, backward) advanced more rapidly than when they were mixed together; the teachers were much more interested in their pupils as individuals; it was necessary to modify the curriculum to meet the needs of the different types of children; the children wanted to go to school, because it was more interesting on the inside than on the outside. Does not this last conclusion give us an idea when we realize the large percentage of juvenile delinquents who began their trouble as truants.

Tests other than the Binet-Simon for levels of intelligence are being devised so that this "inventory of the individual" may be more than quantitative. We wish to know when a child is stable or unstable or psychotic, and when this can be ascertained it will help us to know where we may take him and how it shall be done.

Doll has done much work on what he calls types of intelligence, and speaks of: First, the verbal types, i. e., those who think abstractly, those of whom we speak as the intellectual group. Woodrow Wilson and Secretary Hughes might be taken as of this type among educated people, although even in our institutions for the feeble-minded we find those who, by comparison, would be of this type; second, the manual type, i. e., those who do their best work through their hands, who think in terms of concrete things. Henry Ford and Thomas A. Edison will serve as examples; third, the social type, i. e., those who may not think too abstractly or who may not

construct too well, but whose outstanding characteristics appear in their ability to get along with people. They are the great social leaders (good or bad). They always have followers who are loyal and energetic for their cause, whatever it may be. Theodore Roosevelt and Lloyd George were of the best. The gang-leader of our cities and penal institutions is of the worst.

Of all of our problems, I believe the most important single one is the recognition of the socially-minded individual. Outside he has eight hours of work—if he works; eight hours of sleep—if he sleeps, and eight hours of good or bad influence—as we make it. Before we settle in any detail what we hope to do with and for him; before we make our rules and lay out our courses, showing how we are going to reach our objective; we must know and understand him. We must recognize his type of intelligence and build on that. Many mistakes have been made in the past by trying to carry the socially-minded individual through a course of training built for the verbally-minded or the manually-minded. This fellow needs to be given ideals and to be taught how to live with people, and to lead them (for he will lead) to those things which are good.

In these classifications we are also, as has been suggested, looking for those who are stable, unstable and psychotic. The stable individual is the one who may be relied upon to follow the usual routine wherever he may be! he does not become fussed or upset; he is undisturbed even under trying circumstances. We get into the habit of calling such a person reliable. The unstable individual is irritable, easily disturbed, fussy and becomes upset over little things, and, generally speaking, is not to be too fully relied upon. The psychotic individual you know better than I, so it is not necessary for me to say anything further of him.

(Let me say right here that classification by type—and by stability—and by mental age—may be found in all people, from the exceptionally bright, through to the feeble-minded.)

Having thus found the mental make-up of this child, the teacher's job is put before her. She must train him to his greatest usefulness, and every bit of information that you as physicians can give her as to his physical condition will be of help. Such children can be taught all sorts of useful things; simple for the lower grades and more complex for the higher. She must

follow the great rules of education—from the simple to the complex, from the known to the unknown and from the concrete to the abstract. Very often we think things are simple for a child, when really they are complex. The logical method of teaching writing, when I was a boy, was to have us make parts of the letters until we could finally write the letter, then combine letters to make words, and then combine words to make sentences; but it has been found in the best educational systems that if a child knows what it is to write about it is easier to write a sentence that has a meaning than to write a single letter that does not mean anything to it. So in music, the good teacher has a child try to play a tune it already knows rather than give it first of all a lot of scales or the notes of a piece with which it is not at all familiar. In weaving a basket it is very much easier to put the reed in and out, over and under, when the basket is half-completed, than it is to start it. Logically we would say it is simpler to learn to sew by beginning with learning to thread a needle. but every mother knows that that is very difficult, and so she threads the needle and lets her child undertake to make a dolly's dress, as the simplest way. It will learn much later how to thread a needle. What would we think of a father who, when his child crawls across the floor and says "Dada, Dada," would take the child upon his knee and say: "Wait a minute, you must begin with the simplest sounds and follow them through a logical form; and, according to the scientifically developed stenographic systems, you must learn 'p, b, t, d, chap, jay, gay, kay, etc.'" We would think he was a suitable subject for the State hospital. Yet, unless a teacher really understands what is simple and what is concrete and what is known, she often undertakes to teach the child along lines that he cannot follow at all.

The physician's job is in the field of prevention. This divides into many lines. A few years ago about 360 families were studied in this State. These were families of the children who were already under the care of the State, as feeble-minded, and in about two-thirds of the cases it was found that there was feeble-mindedness in at least two and in many cases more than two generations. In the great Piney district of New Jersey there are many families mating without marrying and bringing into the world large numbers of children, who are sub-normal in intelligence.

Sometimes these children will test normal, until they are three or five or seven years of age, and then they stop. This condition is now known as "Potential Feeble-mindedness." In this hereditary field the physician can give most valuable advice, and should be familiar with the Mendelian law of inheritance, which undoubtedly frequently acts in feeble-mindedness—if both parents are feeble-minded all of the offspring will be feeble-minded; if one parent is feeble-minded, of the inheritable kind, and the other be normal, the children will all appear normal, but one-fourth mated with others like themselves (i. e., containing the determiner for feeble-mindedness) would produce feeble-mindedness, one-fourth containing the determiner for normality would produce normality, and one-half would carry the possibility of producing (if mated with others like themselves) once again, one-fourth feeble-minded, one-fourth normal and one-half carriers of the determiner of feeble-mindedness, although they might appear normal.

These days we are hearing a great deal about the ductless glands, but little is known of most of them, although a great many venturesome things are said. We do know the effect of the lack of functioning of the thyroid, for we get among the feeble-minded the condition which is called cretinism; dwarfish stature, broad placid face, coarse scanty hair, stubby hands and feet, and the particularly characteristic pendulous abdomen. If such a child is given thyroid in small doses, the muscles of the abdomen become stronger, the bones grow, the coarse hair falls out and soft normal hair takes its place, and, most surprising of all, the intelligence increases to quite a marked degree. We do not know of any cretin who has become normal, but there is a distinct improvement. Studies are now being made in various parts of the country of the pineal, pituitary, adrenal and many other glands. In our own institution we have just begun a series of long-time studies with the x-ray. In autopsy it has been shown from time to time that certain vital organs are infantile in size, and so, beginning with the circulatory system, we wish to make complete studies, so that we may know if there is anything abnormal in this ((and later we shall go to the digestive and respiratory system) to see if we can find some anatomical condition that may perchance have something to do with feeble-mindedness.

One thing further—parents frequently

tell us that their doctor has said their child will outgrow this condition of feeble-mindedness. Of course, parents are hopeful, and we do not ask that you destroy this hope, but that you exercise great care in what you say, so that they may not go through many weary years of disappointment; for true feeble-mindedness cannot be outgrown. May I ask you also to get in touch with the research work that is being done in the institutions of New Jersey? Most of it can be of real assistance to you in your practice, and when in your practice you find questionable things that need further study and investigation than you have the time to give them, will you not call upon the research department of your institution to investigate more fully? The isolated cases that go particularly to you, practicing far from the big centers, may well help to solve some of our problems.

I know I am speaking for all of the institution superintendents, when I extend to you a most cordial invitation to visit them, and I emphasize particularly the invitation to visit the Training School at Vineland; it would be a great pleasure to have you meet there with us whenever it may suit your convenience.

Clinical Reports.

SECONDARY LOW BLOOD PRESSURE OF AN INSIDIOUS TYPE

By Louis Faugères Bishop, M. D.,
Sc. D., F. A. C. P.

Formerly Professor of Heart and Circulatory Diseases, Fordham University Medical School, New York City; Physician to the Lincoln Hospital.

New York City.

Secondary low blood pressure is well illustrated by the following case:

This patient is an example of cardiovascular disease of middle and later life, engrafted on a life of semi-invalidism, due to tuberculosis. In 1892 she had a general tubercular involvement of both lungs in spots, with a very marked involvement of the right apex. Her condition was considered hopeless by so good a consultant as the late Dr. Edward Janeway. Nevertheless, on the advice of all consultants concerned, she took up her abode in a suitable part of Arizona, and lived there for four or five years, under the care of a very skillful

nurse, and every possible effort to cure her was made. She made a good recovery and has had no return of acute tubercular trouble, though there is evidence of a large amount of scar tissue in the lungs. During the past summer she had a long period of catarrhal bronchitis, but with absolutely no suspicion of any return of the tubercular disease.

When she was over forty, in spite of the advice and urgent dissuasion of all her medical advisers, she went through a pregnancy and was successfully delivered of a child. During this time she had a very definite decompensation of the heart and was carried through by the use of the Nauheim methods. She received Nauheim baths and systematic exercise, which maintained the compensation of the heart, and at the time of her delivery her blood pressure went above 200 and remained so for a good while. This important point at the present time is that in the treatment of what was probably some form of hay fever, and the injudicious use of saline purgatives for supposed liver involvement, she had undergone a loss of compensatory blood pressure and is in danger, at the present time, of developing all the symptoms which go with inadequate kidney function.

The diagnosis at the present moment is that of secondary low blood pressure (170, when it should be 190), by which we mean a blood pressure of an amount which is less than the person has been accustomed to carry, and appearing at a time when some deteriorating influence has been at work, which either is not sufficient to carry on the functions of the impaired organs, or else is tending in that direction. People can sometimes carry a secondary low blood pressure for a moderate length of time without symptoms, but if the blood pressure maintaining power has been lost they are pretty sure to deteriorate in the presence of any demand for extra circulation.

109 East 61st street.

On one of Mr. Lincoln's trips to Army Headquarters in the Wilderness, accompanied by Noah Brooks, he was driven over the corduroy road in a six-mule army wagon by a very profane driver. Mr. Lincoln stood it as long as he could, then, touching the driver on the shoulder, inquired: "My friend, aren't you an Episcopalian?" "Yes," was the gruff reply. "I thought so. You swear like Seward, and he's a church warden up in Syracuse."—Pickup.

ACUTE PULMONAL TUBERCULOSIS

Remarkable Improvement in a Case.

By **Diego Delfino, M. D.,**

Somerville, N. J.

At the Congress of Medicine, held in Geneva in the year 1905, Bouchard said that patients who mostly are dying from tuberculosis are the ones treated by the physicians. He meant that tuberculosis, when so diagnosed, presents many alterations, so that when it is possible to diagnose a case and start the treatment, it would be very difficult to obtain improvement.

If we stand by the statistics of pathological anatomy, 95 per cent. of patients who died from tuberculosis, showed the presence of tubercular lesions, so when we think of the enormous number of cases of latent tuberculosis we can see evidently that 80 per cent. of tuberculosis cases are healed.

Methods of treating diseases, such as tuberculosis, are extremely varied. In fact one's teachers tell of different ways in which this condition is to be treated in all the stages.

REPORT OF A CASE.

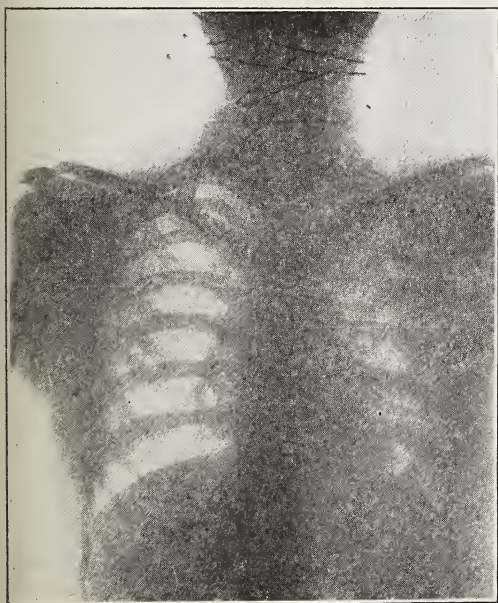
History—A. L., a sixteen-year-old girl, of Allentown, Pa., delicate and pale in complexion; employed as usher in the moving picture theatre for about sixteen months; mother and father living in apparently good health; she has two sisters, one of whom is married and stronger and healthier looking; the family history was otherwise negative.

Symptoms—In December, 1921, patient complained of dizziness; a feeling of soreness extending from the nose down to the throat; hot sensation on the spinal column; coughing and expectorating scanty with mucoid, which was often blood-stained; temperature, 101 fahrenheit, night sweats and anorexia accompanied the rest of the symptoms. This statement was made by both her relatives and herself.

She began treatment with a local physician until January 22, 1922, at which time another physician was called in, who thought necessary an x-ray examination, which was taken on January 23, 1922, showing the following: Left lung, left upper lobe and central portion shows extensive miliary involvement; right lung, few tubercles in region central portion near hilus, otherwise negative.

Examination—On January 31, 1922, was my first visit to the patient, when the T. B. was so well marked upon the general aspect that no examination would have been required in making the diagnosis.

Upon examination, stethoscope revealed, on the upper right pulmonary apex, a sensible characteristic rales, respiration rapid, increased vocal fremitus, dullness, scanty vesicular murmur on left lung, pulse frequent and irregular, temperature 101 fahrenheit. A percussion of the chest, between the sternum and right scapular region, shows hypophonesis, with tympanic sound, more than the left side, in which there was a marked obtusity just above the mamillary line.



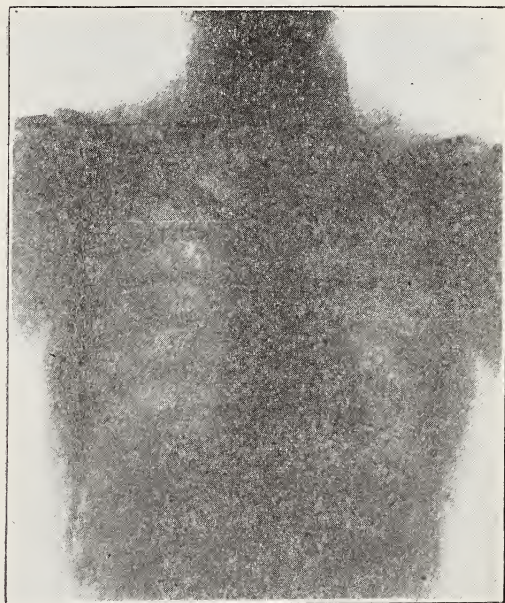
Treatment—Hypodermic injections of iodo-metallic 0.03 mixed with guaiacol 0.05 per dose, daily, in the gluteal region for forty days. R. creosote pure, gm., 8; oil volatile of turpentine, gm., 180; tinct eucalptis, tinct benzoine, aagm., 15; syrup of tolu, gm., 30. Sig.—One tablespoon in a cup of hot water, as for inhalations three times per die.

Internally—Cod liver oil, with hypophosphites. Sig.—One tablespoon four times a day in a little water, wine or milk. Quinine tablets, 2 gr. each. Sig.—One every four hours during temperature, and when necessary. Good azotate food, plenty of eggs and fresh air.

Her condition became progressively improved, relieved of symptoms and

made an uneventful recovery. The x-ray examination taken on March 18, 1922, shows the following:

Subacute, arrested T. B. of left apex; left upper lobe showed decided improvement over plate taken January 23, 1922. Today, April 2, 1922, she can attend to domestic work, feeling stronger, has gained fifteen pounds in fifty days, no temperature has appeared for the last three weeks, no cough, while appetite has increased and sweating is stopped. Treatment at present suspended.



Conclusion—Whether the treatment described was responsible for the remarkable improvement in the case is still an open question. Nature is frequently kind, and when she leads one from mystery to light, we claim that our feeble methods were efficacious and that relief is due to the power of the drugs, so we robe ourselves with glory and pseudoscientific proof of our real help in the case.

As the serum has been manifestly the cause of this young girl's recovery, we shall give it to other poor victims, on the beginning of the disease, in the hope that it will prove equally efficacious.

"Anatomy is the foundation of all sound surgery."

"The Dissecting Room is the stepping-stone to the operating room."

"Pathology is the surgeon's true guide and counsellor."

"Technique is his handmaiden."

—Dr. J. E. Thompson, Galveston.

County Medical Societies' Reports

ATLANTIC COUNTY

Royal E. Durham, M. D., Reporter.

The regular meeting of the Atlantic County Medical Society was held at the Hotel Chalfonte, Atlantic City, on February 9, 1923.

Dr. William Stevenson Baer, of Baltimore, spoke on the "Production of Motion in Ankylosed Joints," and Dr. Emil Goetsch, of Brooklyn, N. Y., spoke on "Recent Studies on Pathology and Surgical Treatment of Goiter."

Dr. Baer emphasized the importance of considering the utility of joints, and urged upon us to cure disease of joints and leave them useful. He spoke of the methods of arthro-plasty used today. There are two methods, i. e., transplantation of free fascia or fat and transplantation of animal membranes. In the latter case the bladder of the pig is used and is chromasized, so as to remain in situ sixty days and then become absorbed. This latter method is better, for the reasons that the animal membrane is less in bulk, more easily handled and hence, with less handling, we have less chance of infection. Likewise, it requires but one operation, as it is unnecessary to get tissue from the patient. This membrane comes ready for use in tubes, as ordinary cat gut does, and is readily obtained from Johnson & Johnson. Dr. Baer then showed an interesting series of slides, showing patients upon whom he had performed this type of arthroplasty.

Dr. Goetsch gave a very interesting and simple classification for all goiters. He said that the normal thyroid gland is composed of alveolar paranchyma epithelial and interstitial or foetal cells, which are dormant. From the alveolar cells we have the following types of goiters: 1, puberty hypoplastic goiter, in which the alveoli are distended and there is an increase in the colloid, with sub-function. This is the colloid type of goiter; 2, the primary puberty hyperplasia; 3, exophthalmic goiter, which is the highest degree of hyperplasia and hyper-function.

From the interstitial cells we have the following types of goiter: 1, adenoma or isolated islands of hyperplasia; 2, diffuse adenomatous goiter. Lues and tuberculosis of the thyroid gland are rare conditions, as are also carcimona and sarcoma.

In the primary puberty hyperplasia we find the adrenalin reaction present and the metabolic rate increased. This type usually responds to rest and hygienic treatment. If, however, it does not respond to such treatment in one year we should operate, as it may become an exophthalmic type. In the exophthalmic type surgical treatment is preferable to medical treatment or xray. The disadvantages of xrays consist of burns and impossibility of accurately measuring dosage. Too little may stimulate the gland too much, while too large a dosage may cause destruction and hyperplasia. Adenoma are always benign, and the hyperplasia of the interstitial cells causes pressure atrophy of the surrounding thyroid tissue. They secrete a toxin, which cause hyper-function of hyper-thyroidism. This type of goiter may undergo

many changes, for it may become fibrous calcified, hemorrhagic, etc. Adenoma may be so small as to be non-palpable, but still produce hyper-thyroidism. The metabolic rate may not be always increased, but the epinephrin test is always positive, and hence is the more important test. The size of the tumor has little to do with its poisoning properties, for this depends on the character and amount of the toxin and the susceptibility of the patient to the toxin. The treatment is always surgical, and, in adenoma xray and radium should not be used.

BERGEN COUNTY

Dr. Frederick S. Hallett, Reporter.

The regular monthly meeting of the Bergen County Medical Society was held at the Union League Club, Hackensack, February 13, at 8:30 p. m. In the absence of the president and vice-president, Dr. A. W. Ward was made chairman. Twenty-three members were in attendance.

The death of Dr. Cornelius A. DeMund, of Ridgewood, was reported. The chair appointed Drs. Vroom and Payne to draft suitable resolutions and to send copies to Mrs. DeMund and to the State Journal.

The scientific committee introduced Dr. Samuel B. English, medical superintendent at Glen Gardner, who gave a highly interesting and instructive paper, "The Difficulties of Diagnosis and Treatment of Tuberculosis." On request, Dr. English agreed to send a copy of his paper to the State Journal for publication.

Dr. English's paper was discussed by Drs. Morrow, Bell and Ward. After adjournment the members enjoyed a social session.

CUMBERLAND COUNTY

Elton S. Corson, M. D., Reporter.

The Cumberland County Medical Society was the guest of Superintendent Thorn at the Home for Feeble-Minded Women, Vineland.

Dr. Samuel T. Day, president, presided. Delegates were present from the Gloucester County Society. Superintendent Thorn conducted the society through the institution. The inmates were seen performing their duties at knitting stockings and making underwear, cooking and varied work required to keep the institution in order.

The speaker of the meeting was Dr. Alfred Gordon, a noted neurologist of Philadelphia. He discussed the subject of "Paresis," popularly known as softening of the brain. He spoke of the early symptoms as being the most important, for later anyone is able to discern the condition. A person normally conservative in speech and manner becomes loquacious or nervously active, or, on the contrary, one naturally cheerful may become morose. Relatives are often loth to admit the condition in one of their family. A person may squander his entire fortune by the simple ability to sign a check without knowledge of its purport, and yet the very act leads the family to think they are of sound judgment. A person usually modest may commit some overt act.

The medico-legal aspect of this stage is most important. A person may be adjudged

guilty of crime when there is no motive for his committing the act. There may be a lapse of normal conscious activity and when the person awakes to normalcy he cannot be made to believe that he has committed the deed.

The society was entertained at luncheon by the home authorities most liberally.

ESSEX COUNTY

Eugene W. Murray, M. D., Reporter.

Sixty-five members attended a meeting of the Essex County Medical Society held at the Academy of Medicine of Northern New Jersey on January 12. Seven new members were elected, and the Welfare Committee's report was received and endorsed. All details, with reference to medical legislation, were explained by Dr. Eagleton, the chairman, and the support of every member of the society was requested. The new members were: Drs. Leon Banach, Robert I. Bull, Emanuel Kline, Daniel R. Mishell, Harry B. Silver, Maurice C. Weinberg, of Newark, and George E. Kalter, of Maplewood.

HUDSON COUNTY

William Freile, M. D., F. A. C. S., Reporter.

The society met at the Jersey City Hospital February 6, 1923, at 8:30 p. m., Dr. L. P. Donohue in the chair.

Dr. A. E. Jaffin, of Jersey City, presented "A Case of Asthma, Due to a Foreign Body in the Trachia."

Dr. James A. Hoenig, roentgenologist, U. S. A. General Hospital No. 16, presented a paper entitled "The Clinical and Radiographic Diagnosis of Chest Diseases," which he illustrated with lantern slides.

Dr. William B. Witherbee, of New York City, spoke on the "Treatment of Tuberculosis Adenitis, Goitre and Diseased Tonsils and Adenoids by the X-ray." Unfortunately, the machine failed, when he attempted to show pictures of the technique, but otherwise the presentation of the condition was appreciated by all present. His talk was discussed by Drs. Axford, Broeser, Finn, Maver and Perlberg on the radiographic line of work.

A synopsis of this paper, with its discussions, will be published in an early issue.

Annual Banquet.

Nearly 200 members of the Hudson County Medical Society, at a banquet Saturday night, February 10, on the roof of the Jersey City Elks' Club, heard their profession charged with commercialism by two lay speakers, General William C. Heppenheimer and Judge Richard Doherty. The General was happy that no such taint has been recognized by him among the medicos of Hudson County. The glib American public was also given a verbal tar and feathering by the philosophical James J. Walsh, M. D., for heeding lorelei lay-by-day-in-every-way songs of Coue and other quacks.

Confessing that he had been a practicing lawyer during the 80's, General Heppenheimer expressed amazement at the change in professional ethics, both among gentlemen of the bar and doctors since then. "In the old days," he said, "professional men felt that their duty to clients was foremost. In those

days there were no cases of malpractice, such as today. The medical profession has gradually drifted into commercialism, as has the legal profession." The General recited several incidents of damage done by chiropractors, which had come to his personal attention, and said in regard to them: "No nation on earth, except the United States, permits such people to be turned loose on the public. They shouldn't be allowed to practice medicine. No sane nation would allow it."

Judge Doherty declared that in less than three months he has noticed four actions against physicians for malpractice, and asked the reason why this should be so. It is almost a new thing in courts, he said. "What has made the public fly back at the surgeons in this way? The answer ought to be in the commercialism which has possessed the profession of late, so that the public has lost respect for the medical man to a certain extent. If your esteem is to be sustained it can best be done by adherence to the traditions of your profession, when humanitarianism prevailed."

The vice-president of the State Medical Society, Dr. Wells P. Eagleton, sounded a note of warning against the osteopaths and chiropractors, and urged organization to curb their machinations in Trenton. He said: "The osteopaths in New Jersey must go to a regular medical school if they want to practice medicine. There are no osteopath bills in Trenton this year, but there will be, and they will go over before many years unless we meet the issue. We have two venereal disease bills, for which we have received bouquets of cabbages and rotten eggs. Venereal disease control is a great problem. If it is not a medical problem, then what is it? The bills, may be wrong, but they are at least an effort by us to help solve the problem. Your duty is not to criticize, but to tell us what solution you see, if you don't like our way."

"In challenging the quacks you are doing an altruistic thing," Commissioner A. Harry Moore remarked, when he was called upon to say a few words. "You realize the harm these people are doing, and you oppose them for that reason, and not that they may seem to encroach in a business way. They can never do that." The commissioner said that the doctor, above all other professional men, is in a position to do service. He then expatiated upon the need, joys and results of service in the world.

Dr. Walsh compared the illustrious Louis Pasteur with the ephemeral Coue. "I was surprised," he said, "how the educated classes flocked to the Nancy chemist in New York. Pasteur and Coue are so different. Coue got his, but Pasteur had to fight for recognition, though it nearly had his life at fifty-four, when he was taken with a stroke. He lived nineteen years after that sickness, and did all his best work in that time. The next time you have a person suffering from a stroke tell him the story of Pasteur. It will help him. Pasteur was called a fool. Nobody would listen to him. Pasteur gave us the vaccine idea, which has saved millions. If the figures of other wars held good the mortality in the late war from typhoid had the allied soldiers not been inoculated against it,

would have been 1,200,000. When Pasteur died they built institutes in his memory. Well, in all these institutes they haven't done as much work since, as he did all alone in his cellar laboratory. If Pasteur, thirty-five years ago, had come here he wouldn't have been recognized. Had Coue come at the same time he would have attracted crowds of followers, as he has now.

"I heard Coue talk in New York, and it was amusing to listen to the way he mixed up his terms regardlessly. He called the imagination the will and the will the desire. As a rule, his patients had nothing the matter with them. Sixty per cent. have much more trouble of the mind than of the body. They are overcome by mental persuasions. You know ailments are nothing compared to the exaggeration the mind creates in respect to them. Everything under the sun at some time or other has cured people. A lot of people can be cured by an idea or suggestion, but these people have no organic troubles. The more I get to know men the less attention I pay to their reason. I have found the best logic in insane asylums.

"There is one thing about Coue, and that is he doesn't ask you to muck over your sex past and be psychoanalyzed, as Freud does. Coue is giving us a wonderful lesson in this country, and until we learn to use suggestion on patients we will turn over many cases to him and his followers. Don't tell a patient there is nothing wrong if he insists there is, but look for the symptom and treat it with suggestion. Coue is now treating tumors and cancers and is doing much harm. The patients, instead of getting good treatment are fooling themselves into believing they are getting better all the time the disease is growing worse. With all Pasteur has given us, are we going to let Coue and these spurious schools take our places? We must use psychological medicine, as well as material. We can't cure cancer, but by suggestion we can make the patient more comfortable while dying."

The toastmaster was Dr. John Nevin, and the committee: Dr. C. J. Larkey, of Bayonne, chairman; Dr. W. J. Sweeney, of North Hudson, and Dr. W. L. Yeaton, of Hoboken. A splendid program of entertainment was provided.

MONMOUTH COUNTY

D. M. P. Magee, M. D., Reporter.

The regular monthly meeting of the Monmouth County Medical Society was held at the Monmouth Memorial Hospital at Long Branch, N. J., on the evening of January 31.

There was a good attendance at this meeting and a marked interest was shown in a number of important subjects, which were brought before it. This was especially true of several legislative bills, and a very interesting general discussion followed on the merits of the various bills presented.

After the regular business was transacted a paper was read by Dr. M. Meltzer, of the Broad Street Hospital, New York city, on the subject of "Kidney Functional Test and Blood Chemistry in Relation to Kidney and Bladder Surgery." This paper was very interesting and was especially so from the standpoint of

the general practitioner. Following the paper, a general discussion was held and the evening was a profitable one to all who attended.

PASSAIC COUNTY

Leon E. DeYoe, M. D. Secretary.

The February meeting of the Passaic County Medical Society was held on Thursday, the 8th, at 8:45 p. m. Dr. Maclay presided.

Dr. Peter Broncato read the paper of the evening on the subject, "Head Colds," their causes and effects. He believed that deformities are the potential causes of head colds. These may be traumatic, or development, causing poor drainage of the accessory sinuses, and it is his opinion that this lack of drainage is the basic factor in head colds. Discussion by Drs. Willard, Henion, Roemer, Van Winkle and Marsh.

The following resolution, offered by Dr. Marsh at the last meeting, was adopted:

"Whereas, The practice of bringing unjustified suits for damages from malpractice against physicians and surgeons is becoming increasingly prevalent, and

"Whereas, Most of these suits would fall if not supported by the testimony of other physicians, and

"Whereas, Every such suit settled or compromised is an invitation to another suit, while every suit defended to the legal limit is a deterrent to other such suits, and

"Whereas, The Medical Society of New Jersey, by authority of its House of Delegates, has made a contract of insurance and indemnity in such suits, with a reputable indemnity company, which contract has been accepted by the Trustees of the said State Society and indorsed by this society, and

"Whereas, In this contract the society pledges its good will and moral support and that of its members in defense of such suits; therefore be it

"Resolved, That any member of this society who shall agree to settle or compromise any suit for damages arising from malpractice, without the consent of the Board of Censors, or the judicial counsel of the State Society, shall be liable to a charge of unprofessional conduct. And that any member who shall testify in any trial of this character against any medical practitioner, save as to matters of fact, when under subpoena, without like consent, shall be liable to a similar charge; and be it further

"Resolved, Also that the society directs the attention of its members to the defence and indemnity contract of the State Society, and recommends their taking insurance thereunder."

SOMERSET COUNTY

Benjamin Borow, M. D., Reporter.

The regular bi-monthly meeting of the Somerset County Medical Society was held at the Court House on February 8. The meeting was called to order by the president, Dr. William H. Long, and the regular business was transacted. We then had the pleasure of listening to an address by Dr. C. R. Keppeler, of Newark, N. J., who took for his topic "The Latest Developments in Orthopedic

Surgery." The meeting was then thrown open to all members for discussion on Dr. Keppler's topic. After considerable discussion the meeting was regularly adjourned.

Local Medical Society Reports.

BAYONNE MEDICAL SOCIETY

The Bayonne Medical Society met on January 15, 1923, at the Elks' Club. Dr. D. I. Nalitt reported a case of strangulated hernia. Dr. W. W. Brooke reported the following cases: 1, a case of prolapse of the rectum, following a Whitehead operation; 2, a case of malignancy of the pleura, following a breast tumor; 3, a case of post-operative adhesions producing obstruction; 4, a case of strangulated femoral hernia. Dr. F. A. Finn reported a case of osteo-sarcoma of the foot, developing within one month after injury; also a case of ununited fracture, due to syphilis, which healed under antiluetic treatment.

Dr. Sydney Chayes then read the paper of the evening entitled "The Undernourished or Subnormal Child." He reviewed the statistics of these types of children and the defects found among them and among the young men of the country, as shown by the examinations during the drafts. He discussed the various methods used in the nutrition classes, the types of food necessary, the proper habits to instill, and made a plea that the practitioner should take an active part in the work, so as to make these children come up to standard, to keep them there and to have all healthy children conserve their health. He asked that all should take an active part in this great work in order to conserve the most important asset of the country.

Discussion: Dr. Riha stated that the physician is of greater service to those in health than to those who are ill. The country needs a bureau of child care. Wild animals intuitively eat and drink wisely, while man eats and drinks unwisely. Civilization seems to make people unwisely. He believes that meats are essential to children for growth and nutrition. Carbohydrate diet exclusively ruins the teeth, while protein preserves them. Children should receive Vitamin C and fat soluble Vitamin. Vegetables are important to supply salts and filler. Overfatigue and lack of sleep are causes of poor appetite. Dr. Larkey stated that the work with the undernourished child should be taken up with interest by the entire profession. Defects frequently cause undernourishment. Cakes and sweets should be prohibited, as they spoil the appetite for wholesome food. Sufficient time should be given to feeding. Rest and proper food (amount and kind) are necessary to proper nourishment.

Dr. Chayes, in closing, stated that milk and, if necessary, cod liver oil should be supplied to the undernourished children in the schools.

M. Coue.—If he had done nothing else, M. Coue would deserve consideration for having crowded the monkey gland experts off the stage.—Portland Oregonian.

PRACTITIONERS' SOCIETY, EASTERN MONMOUTH

D. M. P. Magee, M. D., Reporter.

On January 11 a regular meeting of the Practitioners' Society, Eastern Monmouth, was held at the Monmouth Memorial Hospital, and a good supper was enjoyed by those present. President Herman occupied the chair, and the attendance was very good.

Dr. B. W. Moffat, of Red Bank, was proposed for membership and was referred to the membership committee. The paper of the evening was read by Dr. L. S. Loizeaux, F. A. C. S., of Fifth Avenue Hospital, New York city, on "Some Obstetrical Problems From the Standpoint of the General Practitioner." This paper was an excellent one, and the discussion following it proved the general interest which was taken in the subject. Those who were present spent a very enjoyable and a very profitable evening. The society aims to have a good paper on some interesting subject by some one who is an authority at each of its monthly meetings.

SUMMIT MEDICAL SOCIETY

W. J. Lamson, M. D., Secretary.

The regular meeting of the Summit Medical Society was held at the Canoe Brook Country Club on Friday, February 23, 1923, at 8:30 p. m., the vice-president, Dr. Lawrence, in the chair, and Dr. Campbell entertaining.

Despite the fact that it was the coldest night of the winter, the following members were present: Drs. Alexander, Baker, Campbell, Clark, Krauss, Lamson, Lawrence, Meeker, Morris, Prout, Tator, Tidaback and Milligan.

The paper of the evening was read by Dr. J. W. Gardam, of the Newark Board of Health, on "The Schick Test."

Dr. Gardam said that it was estimated that the cases of diphtheria in the United States in 1922 were 212,000, and the deaths from this cause, 12,000, and that approximately 1 per cent. of the entire population are carriers. Hence the importance of determining who are susceptible, and protecting them with Toxin-antitoxin. He described the technique of the Schick test and the various types of reaction which occur. The dose of Toxin-antitoxin now given is much smaller than originally used. He spoke of the increasing use of the test in schools, institutions, etc., and of the work done in New York, Newark and elsewhere.

The discussion was general, and many questions of details in connection with the test were asked.

Dr. Krauss reported a very interesting case of mixed streptococcus viridans and diphtheria infection in a six-year-old child, involving successively the sinus, antrum, middle-ear, mastoid, ethmoid and other cells on the right side, which finally recovered, after opening and draining all these organs, as they became affected.

Dr. Charles Schwinn, Camden, has been appointed superintendent of the Sunny Rest Sanatorium, Angola, to succeed the late Dr. Joel W. Fithian.

NEW JERSEY SANITARY ASSOCIATION

Edward Guion, M. D., Secretary.

The forty-eighth annual session of the New Jersey Sanitary Association was held, as scheduled, at the Laurel House, Lakewood, N. J., December 1 and 2. A very large attendance was evidenced by the fact that about forty persons had to seek accommodations outside—they having neglected to make reservations. It is worthy of note to state that there were more women in attendance this year than ever before.

The program, while lengthy, was intensely interesting and instructive, and the speakers kept to their time limit. President Charles V. Craster, health officer, Newark, presided.

The officers elected follow: E. J. Marsh, M. D., Paterson, president; Honorable T. Frank Appleby, Asbury Park, first vice-president; Charles W. Crankshaw, M. D., Newark, second vice-president; Louis Richards, Elizabeth, third vice-president; Chester G. Wigley, C. E., chairman executive council; Herbert Baldwin, Newark, treasurer; Edward Guion, M. D., Atlantic City, secretary.

Nearly fifty new members were elected to membership.

The association, by vote, adopted the recommendation of the executive council to apply for membership in the American Public Health Association, as the representative sanitary association from New Jersey, it being understood that there would be no change in the name of the New Jersey Sanitary Association.

New members to the executive council are as follows: Samuel L. Salasin, M. D., Atlantic City; T. J. Headlee, New Brunswick, and James E. Brooks, Glen Ridge.

ACADEMY OF MEDICINE OF NORTHERN NEW JERSEY

The stated meeting will be held March 21, 1923, at 8:45 p. m. Addresses will be delivered by President Dr. Schweinitz, of the A. M. A., and President Hunter, of the New Jersey State Society. The anniversary discourse will be delivered by Professor J. M. T. Finney, of Johns Hopkins, Baltimore, Md.

The Section of Eye, Ear, Nose and Throat will meet on March 12 at 8:45 p. m. The paper on "The Bronchoscopic Treatment of Lung Abscess" will be read by Dr. Harvey Hall Forbes.

The Section of Pediatrics will meet on March 13 at 8:45 p. m. Report of cases and a paper will be presented.

The Section on Surgery and Obstetrics will meet on March 27 at 8:45 p. m. After report of cases, Dr. Robert E. Soule will read a paper on "Operative Treatment of Fractures," with lantern-slide illustrations.

The meeting will be held at 91 Lincoln Park, Newark.

Typhoid Fever in World War.—There was less than one case of typhoid fever during the World War to each ninety-four cases during the Civil War, and to each 140 cases during the Spanish-American War and Philippine Insurrection.

To Be More Tolerant

Many of my esteemed readers who appreciate *The Critic and Guide* and agree with me in the main on all subjects discussed, say that my attitude towards many of the irregular cults is too intolerant. I preach tolerance towards all social heresies, and I ought to be more tolerant towards medical heresies.

But it is not the same thing. Opinions on social, economic and religious topics are the result of abstract reasoning and not susceptible of scientific proof. How can I be tolerant towards things which can be proved to be wrong, which can be proved to be absurd and ridiculous?

I have but one criterion to go by; and that is reason. My reason may be wrong. But as long as I do not reject it as the sole criterion of what is true and false, I cannot act otherwise than I do. * * *—*Med. Critic and Guide.*

And So Coue Is Here

Again and again I have been asked to write in greater detail than I have about Coue and his system.

No, it is not worth while wasting time and paper. Whatever is true in Coue's system is not new and whatever is new is not true. He may do some good to neurotic and hysterical women; and he may do some harm.

On the whole, he will not influence the course of medicine in the slightest. In this respect the vast majority of the people remain sane. The Abrames, Coues, Chiropractors, Christian Scientists, Wild Psychoanalysts, Mental Thinkers, etc., can only ameliorate or can only ameliorate or remove hysterical and neurotic symptoms and imaginary diseases.

When followers of these cults will show me how, by their methods, they have caused the disappearance of a stone in the kidney or bladder, dried up a gonorrheal discharge or dilated a stricture, straightened out club feet or hunchback or genu valgum of genu varum, saved the life of a bleeding woman with a ruptured extrauterine pregnancy, or even cured such a simple thing as scabies or favus, then I will give them a more respectful hearing.—*Med. Critic and Guide.*

Feelings.—A New York banker, aged eighty, recently, seriously grieving over the loss of his wife, with whom he had lived many happy years, was advised by a friend to try "Christian Science." He was introduced to a healer, a handsome woman, who lived in a beautiful home and wore beautiful clothes, and possessed a beautiful voice. The old gentleman told her his story and she proposed that they kneel down. Holding his hand she read to him from Mary Baker Glover Eddy's books at great length. Then she rose, and when he had risen she said brightly: "How do you feel now?" "Well," said he, "I feel like a damned fool! How do you feel?"

Nutritional Problems of Children.

An Institute on the Nutritional Problems of Children will be conducted by Dr. W. R. P. Emerson, of Boston, in Newark, from March 5 to 17, at the Board of Health Building, Plane and William streets.

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Each member of the State Society is entitled to receive a copy of the JOURNAL every month.

Any member failing to receive the paper will confer a favor by notifying the Publication Committee of the fact.

NOTE.—The transaction of business will be expedited, and prompt attention secured if,—

All papers, news items, reports for publication and any matters of medical or scientific interest, are sent direct to THE EDITOR, New Brunswick.

All communications relating to reprints, subscriptions, changes of address, extra copies of the JOURNAL books for review, advertisements, or any matter pertaining to the business management of the JOURNAL are sent direct to THE CHAIRMAN OF THE PUBLICATION COMMITTEE, Newark

CORRESPONDING SECRETARY.

President James Hunter, Jr., has appointed Dr. William J. Carrington of 905 Pacific Avenue, Atlantic City, Corresponding Secretary of the Medical Society of New Jersey, to fill the vacancy caused by the death of Dr. Harry A. Stout. The Society will be efficiently served by this appointment.

REGRETS AND EXPLANATIONS

The Editor regrets exceedingly that the insertion of the Index of Volume XIX has to be deferred until the April Journal. Sickness to himself and others in his home delayed its completion till February 24, and pressure of work at the printing office are the causes.

The Official List of the Society will probably not go as a supplement with our Journal until the May issue. While the Editor and the chairman of the Publication Committee are in no way responsible for the compiling, accuracy and date of issue of that list we noted that the mistakes in the lists of officers, committees,

members and their residences were so numerous in the galley proofs that the publication of the document should be deferred until its author—Dr. Chandler—returns home, about April 15, from his winter's sojourn in Florida. In the meantime the lists of members and their residences will be sent to the secretaries of the different county societies, who are really most responsible for promptness and accuracy.

WE CONGRATULATE THE ACADEMY OF MEDICINE.

The new auditorium of the Academy of Medicine of Northern New Jersey is completed; it has a seating capacity of over 400. It is a fireproof structure, has a separate projection room which will permit exhibits of moving pictures. It is beautifully decorated and handsomely furnished. It was erected at a cost of \$30,000, financed entirely by the membership.

The stage furniture was presented to the Academy as a memorial to Dr. Fridolin L. Ill. Sixty-eight chairs in the auditorium are memorials to physicians, who were active in their profession, their names engraved on plates will be a reminder to the living of their faithful work, their accomplishments, the value of their labors to the profession and community; among those memorialized might be mentioned "Fellows" of our State Society: Wm. O'Gorman, Alexander N. Dougherty, Charles J. Kipp, Wm. Pierson Jr., and Frank D. Gray.

On March 21st, 1923, at 8.45 P. M., will be celebrated the dedication and anniversary exercises, to which the public is invited. The program is given in full on page 100.

AN ARISTOCRACY OF BRAINS.

The President of Dartmouth College has asserted that too many men go to college; he deems it necessary to define the individuals to whom in justice to the public good, the privilege shall be extended, and to specify those from whom the privilege should be withheld. He believes there is such a thing as an aristocracy of brains, made of men intellectually alert and intellectually eager, to whom increasingly the opportunities of higher education ought to be restricted. —Ill. Med. our.

A LAY EDITOR'S VIEW OF THE NOSTRUM EVIL

Capper's Weekly, a Minnesota paper published by Senator Capper, has been publicly denounced by the Fairmont (Minnesota) Daily Sentinel as a paper claiming for its motto "A Champion of Human Welfare," but containing "column after column of the vilest, lowest, beastliest, most misleading, deceptive, dishonest and debauching advertisements of nostrums and alleged cures of diseases that are contained in any paper in the United States that is permitted to circulate through the mails."

It is encouraging to find lay editors who will come out boldly and say what they think about the type of fraudulent medical advertising that is still printed in so many publications. The American Medical Association is doing its best to protect the country against this sort of deceit. We welcome to the ranks all others who will aid in this much-needed housecleaning.—Boston Med. and Surg. Jour.

EMILE COUE'S VISIT TO AMERICA.

We believe the following extract from an Editorial in the A. M. A. Journal concerning druggists Coué's visit to Chicago, further sufficient comment on the man and his work.—Editor.

Mr. Coué claimed that much of human suffering and disability is psychic in origin, the outcome of faulty thinking. All that is necessary for its relief is a change in the mode of thought. This can be achieved by the persistent and insistent repetition of a formula, which disavows the trouble. He acknowledged that some things cannot be changed, as for example the loss of a leg, and that it is useless to attempt "the impossible." However, despite the protestations that he will not attempt "the impossible," Coué frequently finds it "impossible" only when he fails. One of the patients subjected to "treatment" at the Chicago meetings was an elderly woman, emaciated, feeble, short of breath, and with every appearance of cardiovascular disease. This poor woman was urged, stimulated and encouraged to walk vigorously, even to run. Under the stimulus of the excitement, she succeeded temporarily by the exercise of every reserve of energy, and after having served the purpose of this ruthless demonstration, retire from view, to sink panting and exhausted in a chair. No more

serious result was evident, but risks had certainly been taken without thought to the possible dangers, which were obvious to any physician. The atmosphere of the Coué demonstration contained much to recall the vaudeville hypnotist, now almost extinct; the magic word, the mesmeristic passes and ever the old parlor trick of suggesting to members of the audience that they could not separate their hands after they had pressed them tightly together, all bring back memories of the professional hypnotist. Had it not been for the pathetic background of the crippled, deformed and disappointment-doomed dupes that filled the stage, the scene would have been humorous. The methods and theory with which Coué works are as old as history. Nancy, the town from which he came, was the home of a school of scientific hypnotism, under the leadership of Liébeault and Bernheim, which was famous in the sixth and subsequent decades of the last century. It is an error to assume that physicians have ignored such merits as do underlie these practices. The abrupt relief of hysterical symptoms by suggestion and persuasion is a commonplace in the practice of the average physician. Suggestion has a distinct place in therapeutics; unconsciously, it is used by every successful physician in the form of encouragement and optimistic prediction. It is the basis of Eddyism. But suggestion, while it may, and often does, give temporary relief, does not cure; it must be accompanied by investigation and remedy to the underlying causes, whether psychic or physical.

THE PRACTICE OF MEDICINE BY THE CLERGY.

From the Boston Med. and Surg. Journal.

According to Dr. Egbert H. Grandin, of New York, a movement has been inaugurated for the purpose of legalizing an alleged method of curing disease by the laying of hands, according to the methods employed by Mr. Hickson.

The champion of this movement is the bishop of New York. He is reported to have given Mr. Hickson every opportunity to demonstrate his methods when he, the bishop, was rector of Trinity church. If this report is true it is time for the medical profession to put aside its conservative attitude and take the field in a campaign of opposition to any plan which seeks to deceive the people.

Physicians have been reluctant to enter upon any controversy involving the application of religious faith in the cure of disease through mysticism, for physicians as a class share with the great majority of mankind a profound respect for true religion, and so far as religious teaching and practice are applied to the spiritual and moral nature, extend encouragement and support. But the profession as a body understanding the behavior of those diseases which have a recognized pathology, would resent the impious assumption that the operation of natural laws can be suspended by methods which appeal to the emotions rather than to reason. If it could be shown that the Deity is disposed to suspend the known laws of disease, physicians would forsake their arduous tasks and enter the orders of the church, but experience has demonstrated that certain diseases are inexorable and do not respond in any great degree to the mental or moral attitude of the sufferer. It is, of course, generally conceded that functional conditions can be materially modified or a cure effected through changing the mental attitude. If this phase of treatment is recognized and given its proper application, the psychic effects of good counsel and the encouragement extended by a dominating personality have their proper places.

The clergy will hold their position of influence so long as they deal with the problems of ethics and religion, but diseased minds, as well as bodies, must, in the end, be presided over by painstaking and competent physicians. The people must beware of false teachers, even though they are in high places.

THE BUSINESS SIDE OF THE MEDICAL PROFESSION.

COMPARISON OF THE MEDICAL MAN WITH MEN OF OTHER PROFESSIONS.

In an extensive acquaintanceship among medical men I have found but a very small percentage who could be credited with having a well-balanced business side, and indeed it has always been an open question in my mind as to just why they had adopted this profession. Surely, they were not dominated by a mercenary motive, as the remuneration is so small that it is difficult to see how the ordinary medical practitioner makes ends meet. This being the case,

the only solution to the problem is that they have adopted this calling with the sole desire of serving humanity, as few of the get rich.

Let us compare the average medical man with the same type of citizen in another profession. The medical man can hardly make an existence while pursuing his studies, and with all the requirements necessary for him to qualify he will have reached the age of 27 or 28 years before he is able to "hang out his shingle" and conduct his business. No matter what size town he locates in he will be several years building up a clientele and meanwhile he is subject to call at any hour of the day or night.

He must conduct an office at an address situated in a fair, decent locality, and in addition to the equipment necessary to his profession, he should have some means of conveyance, preferably a motor car, even though it be of the "Lizzie" type. Everyone in the neighborhood looks up to him as a prosperous citizen and he has to live up to this reputation even though at a cost of self-denial.

Probably after many years of this kind of life he may rise to the dignity of receiving fees running up into the hundreds of dollars, but the greater number of instances show that he is fortunate to receive only single dollars. Indeed, where there is one doctor who can get hundreds, there are hundreds of doctors in the latter class where a \$10.00 fee is regarded as magnificent.

Then, there are many doctors who have to provide medicine to go with the fee, and this is another addition to the overhead. Without being in a position to know definitely, I should figure that after the ordinary doctor has paid his legitimate and necessary expenses he will be fortunate if at the end of the year he can figure his actual earnings at \$2,000 per year. And it must be borne in mind that this does not begin until he has reached his thirtieth year.

Now, let us look upon the other side of life. In business the salesman who is at all fit can easily knock out a salary of \$3,000 to \$5,000 annually. The mechanic can command at least \$2,000, with pay as an apprentice while learning his trade, which the doctor does not get. If a man is only of mediocre ability in commercial life he can figure in the \$3,000 to \$10,000 class, and even the skilled laborer will overtop the physician in his

earnings. Let us take the street car employee as an illustration. In Philadelphia the scale is now 62c per hour for motormen and conductors. Most of them work ten hours a day and 313 days a year, and at this rate they receive over \$1,900 annually in wages. This gives them 14 hours a day for themselves and at least one day off in every seven. No preliminary education is necessary to fill this post and perform the duties, and it is true that not many of these men have much more than a common school education. When the day's work is over there is nothing to think of except amusement, relaxation and a full night's sleep, but with the physician he never knows when or at what hour he is going to be called upon to administer to suffering humanity.

The question, therefore, recurs that if the professional man looked upon his profession from a strictly business viewpoint he would demand much larger fees than those he receives at present, and looking at the matter from a layman's side, I am at a loss to understand why some step was not taken long ago by medical men looking to the stabilizing of their fee charges.

It may be, however, that they are deterred from such a stand, fearing the charge of commercialization. On the other hand, it may be that they love their profession too much to regard it from a strictly business angle. — Robert Haight in Penn. Med. Jour.

MEDICAL PRACTICE.

From the Minnesota Medical Jour.

The Minnesota State Medical meeting at Minneapolis may be likened to a squall that ruffled the rather turbulent waters of the present medical situation. It is generally admitted that the practice of the healing art is going through a definite transition stage brought about in part by the development of the medical specialties and in part by the so-called cults, with the tendency toward state medicine ever lowering in the background.

Specialism has led to the formation of clinical groups, and group practice has its champions and detractors. There is little question, however, but that group practice has its advantages and has come to stay. Specialists are absolutely necessary and their need will become even more apparent as the science and art of

medicine develops further. On the other hand, there will ever be a demand for the general practitioner to handle the large percentage of patients, estimated by some as 85 per cent., who do not require a specialist's care. The higher fees and easier professional life of the specialist strongly attract recent medical graduates, but the necessity for several years of general practice before adopting a specialty cannot be too strongly emphasized. The narrowing effect of specialism exerts only too strong an influence on the sound judgment of the physician.

It is being argued that the dearth of general practitioners has led to the phenomenal growth of cults—the chiropractic in particular. Whether this is the case or not, efforts should be directed toward encouraging recent graduates to enter the general field. Whether this will necessitate a shorter period of medical training is open to question, for it is difficult to see just where the standard medical course of today could be abbreviated to advantage.

As a matter of fact, much apparent specialism is not real specialism. Many physicians are working gradually into a specialty and this is as it should be. Only too many of the profession are demanding the specialist's fee who are not entitled to it.

At the present time much energy is being exerted in an effort to counteract the evils of the so-called cults. It would be well if some of this energy were directed towards house-cleaning in the ranks of the organized profession itself. Most county societies include in their membership medical men who are crooks and are recognized by their associates as such and who have no place in our ranks. The house-cleaning should go still further and extend to the unprincipled physician who is outside the county society and whose license should be revoked. Every board of medical examiners knows the difficulties to be encountered in depriving a licentiate of his right to practice and often the blame cannot be placed at the door of the medical profession. Every physician is human and makes errors and is therefore loath to point the accusing finger at his fellow practitioner. Nevertheless, a continuous warfare must be constantly maintained against the man who disgraces himself, his medical associates and the honorable profession of medicine.

THE TITLE "DOCTOR"

The Lord, who knows all things, knows that there is not a bit of snobbery in my makeup. He knows that I am genuinely democratic—not in the present-day sham significance, but in the genuine meaning of the term. Race, color, creed or social position mean nothing to me. I judge of every person by his or her internal worth, character and principles.

And yet I cannot swallow the vulgarization of the title "doctor" in this country. I cannot become reconciled to the manner in which it is cheapened and adopted by every ignoramus who is no more entitled to it than I am to the title of the Pope of Rome.

When a patient comes to me, introduces himself as "doctor" and tells me his troubles and I begin to discuss them with him and quickly notice that he is not familiar with the most ordinary medical terms, and he then explains to me that he is not a medical doctor, but a "doctor" of chiropody, I cannot help raising my eyes and shrugging my shoulders. And when at a banquet given to a radical writer I am introduced to a Dr. So and So, who, during the conversation, shows a complete innocence of any knowledge of medicine and uncovers himself later as a doctor of chiropractic, I cannot help feeling squeamish. When I think of such men as Lister, Osler, Virchow, Koch, Nothnagel, Ehrlich, Fournier, Jacobi, Meltzer, Flexner, Loomis—from the lips of many of whom I imbibed my medical knowledge—and compare them with many of the utterly ignorant quackish laymen, corncutters and rubbers, who appropriate the title of "doctor," I cannot help feeling disgusted.

It isn't right. It is not right that men whose entire knowledge can be compressed within half a dozen lessons should appropriate the same title which has been worn by the foremost genuises and by the greatest scientists and investigators of the age. For it must be borne in mind that many of our great physicians of the present day were not simply physicians, but also great chemists, biologists, physiologists and psychologists; the greatest in the world. It isn't right.

And by the way, the chiropodists, who are not pleased with the title of chiropodist, have adopted a new title, that of podiatrist—don't confuse it with pedia-

trist. We have had some requests for sample copies of "Pediatrics" from correspondents who were under the impression that "Pediatrics" was a journal dealing with chiropody, and not with diseases of children. So broad is their education.

A glorious country for one with lots of brass and push.

And to see the scorn with which chiropodists look down upon manicurists! What is the difference? Is it really so much more complicated to trim the nails of the toes than it is the nails of the fingers?—Dr. Robinson, editor, Critic and Guide.

FEW PUBLIC CLINICS NEEDED.

Dr. Merrill H. Champion, director of the Massachusetts department of health, at the meeting of the American Public Health Association at Cleveland, Ohio, October, 1922, flayed the treatment of disease by the government. He stated that the unwarranted use of material relief whether in the form of food or medical treatment goes to destroy the sense of responsibility on the part of the individual and results in his pauperism, he said. "Public clinics should be kept within the bounds of absolute necessity."

CORRESPONDENCE

Human Actinomycosis.

To the Editor—I am endeavoring to make a complete study of the distribution of human actinomycosis in this country. The number of cases reported in the literature is surprisingly small, and I know that the disease is not so rare as is sometimes thought. I shall greatly appreciate hearing directly from anyone who has had experience with this disease, and desire to know concerning case histories the following: Age, sex, occupation, residence, State in which the disease was contracted, location of lesion, duration of symptoms and any special points of interest connected with the treatment, outcome of the disease, or necropsy findings.

A. H. SANFORD, M. D.,
Mayo Clinic, Rochester, Minn.

"What is death

To him who meets it with an upright heart?
A quiet haven where his shattered bark
Harbors secure, 'till the rough storm is past.
Perhaps a passage overhung with clouds,
But at its entrance; a few leagues beyond
Opening to kinder skies, and milder suns
And seas pacific as the soul that seeks them."
—James Hardis.

DE MUND.—A report is just received, as the Journal goes to press, of the death of Dr. Cornelius A. De Mund, of Ridgewood, Bergen County. Further notice will be given next month.

Miscellaneous Items

Lay Educational Fund.—Over 500 members of the Illinois State Medical Society have subscribed to the fund to educate the public as to the profession's methods of serving the public by use of the newspapers of the State.

Gifts to New York Academy of Medicine.—Gifts of \$1,000,000 each are reported to have been made by the Rockefeller Foundation and the Carnegie Corporation to the New York Academy of Medicine, according to the New York Times. A part of the money is to be used in the erection of a twelve-story home for the Academy, which is planning an enlarged program for the information of the medical profession and for the instruction of the public in preventive medicine.

The Centenary of Jenner.—On the 28th of February we should have commemorated the centenary of the death of Jenner, and, strange to say, just after a smallpox outbreak. As the antivaccinationists are still with us, the figures showing the decline of smallpox in successive decades during the period of general vaccination may be given: 1867-1876, 58,614 deaths; 1877-1886, 18,026 deaths; 1887-1896, 4,892 deaths; 1897-1906, 4,763 deaths; 1907-1916, 139 deaths.

Influenza Germ Isolated.—Isolation of the influenza germ, "bacterium pneumonitis," and the presence of a mild influenza epidemic in parts of Europe and throughout the United States were announced under direction of the State Department of Health. Dr. Simon M. Flexner, director of the Rockefeller Institute for Medical Research, who prepared the address delivered here, said that Dr. Frederick T. Gates and Dr. Peter K. Olitsky, of the institute, isolated the germ. So small is the germ, Dr. Flexner declared, that it must be magnified 1,000 times before it is seen distinctly under the microscope. It was learned that the germ lodges in the nose and throat during the first thirty-six hours of infection, then attacks the lungs in such a way as to make them susceptible to other germs in the nose and throat, notably pneumonia and bronchitis.

A Chiropractic Advertisement

The following is an advertisement which appeared in the Chicago Tribune for Oct. 20, 1922. It is sandwiched in between two other advertisements; on the top of it is an advertisement of a school of motoring; on the bottom of it an advertisement reads, "Take up Barbering. Demand and Wages the best," etc. The chiropractic advertisement reads as follows:

"Become a Doctor of Chiropractic"

"Three months' evening course. Simule and easy to learn. Low tuition. Graduates in demand. Degrees D. C. and Ph. C. conferred. National University of Chiropractic and Hospital, 2923 So. Michigan Ave."

That's all.

When we say that the requirements for be-

coming a chiropractor are not very high, when we say that people without any preliminary education, who become "Doctors" in three months of so-called evening study, cannot know very much about the human body and about diagnosis and treatment of disease, we are snarled at and called all kinds of names.

What do you think of a system of "medicine" that grants diplomas of "Doctor" after a three months' evening course? What shame what prostitution of the profession of medicine!—Critic and Guide.

Quackery Thrives on Ignorance

"No laws will ever be able to prevent quackery, while people believe that the quack is as honest a man, and as well qualified, as the physician. A very small degree of medical knowledge, however, would be sufficient to break this spell; and nothing else can effectually undeceive them. It is the ignorance and credulity of the multitude, with regard to medicine, which renders them such an easy prey to every one who has the hardiness to attack them on this quarter. Nor can the evil be remedied by any other means but making them wiser. The most effectual way to destroy quackery in any art or science is to diffuse the knowledge of it among mankind."

This might have been written in 1922 apropos of the founding of the new lay journal by the American Medical Association. But it was not. It was written by a physician in London in 1783.—A. M. A. J.

Workman's Insurance in Germany a Failure

Dr. Friedensburg, for a period of twenty years prior to 1911 the president of the Senate of the Imperial Insurance Office of Germany, has given his views upon the practical results of workmen's insurance in that country, and they constitute virtually an indictment of the system. Some one, in summarizing the series of charges, made by Dr. Friedensburg, points out the three most significant as follows:

"The first is that the State insurance, specially designed to replace pauperism and charity, is itself merely pauperism under another form. The second charge is that it has fostered to an incredible extent the German evil of bureaucratic formalism. The third and the worst charge is that it has become a hotbed of fraud, and, therefore, a spreader of demoralizing practices and ways of thought."

Medical Corps, Regular Army

An examination of applicants for appointment in the Medical Corps of the regular army will be held during the period of July 16 to 20, 1923, inclusive.

To be eligible to take the examination, the applicant must be a male citizen of the United States, a graduate of an acceptable medical school legally authorized to confer the degree of doctor of medicine, must have had at least one year's hospital training subsequent to the completion of a four-years' course of instruction in such medical school, or, in lieu thereof, have served one year as a medical

officer in the United States Army, between April 6, 1917, and July 1, 1919, and must be between the ages of 22 6-12 and 31 6-12 years at the time of examination. Former officers of the medical department, regular army, honorably separated from the service, and within the age limits and otherwise eligible, will be permitted to compete in the examination. Blank form for making application to take the examination may be obtained at any military station or from the adjutant-general of the army, Washington, D. C. The application should be mailed to the Command Officer, Second Corps Area, Governors Island, N. Y. Approved applicants will be informed as to the exact place, date and hour where the examination will be held, in ample time prior to July 16, 1923.—F. R. Keefer, Surgeon.

Pushing a Bill at Trenton to Encourage Lawbreakers

Putting a premium on violation of the law is apparently intended by a bill pending in the Legislature, introduced by Assemblyman Harbourt, favorably reported and passed on second reading in the House. It provides that any person who is a graduate of a recognized school of chiropractic and was a resident of New Jersey on July 31, 1921, and was actively engaged in the practice of chiropractic on that date, shall be given a limited license by the State Board of Medical Examiners.

Now the fact is that any chiropractor legally practicing on that date has no need of a license. The old Chiropractor License Board act was repealed on March 31 of that year, and those who had been licensed by it were authorized to continue practice without further action. Others, in order to practice, had to secure a license from the State Board of Medical Examiners. Any person practicing this profession between March 31 and July 31 without a permit from either the old board or the new was doing so illegally. Assembly 225 would apply only to cases of that sort. Its passage and approval would be an encouragement by lawmakers to those who break the laws, and the examining board would be compelled, despite this fact, to issue such licenses.—Newark Evening News.

Term "Injury" in Ohio Workmen's Compensation Law Construed.

The Supreme Court of Ohio has decided* that the term "injury" in the Workmen's Compensation law does not include diseases contracted in the course of employment, and accordingly holds that death from typhoid fever is not compensable. The question of the compensability of occupational diseases was not involved in the case. The following is a portion of the court's opinion:

... But in view of the constitutional interpretation, in view of the fact that during the eight years that the compulsory compensation law has been in force, the industrial commission has given the term "injury" an interpretation which excludes diseases which are contracted as distinguished from diseases which are occasioned by or follow as a result of some physical injury, and in view of the fact that to interpret the term

"injury" as including diseases generally would enlarge the scope of disabilities compensable to such an extent as to either bankrupt the fund or require a complete readjustment of premiums upward, we hold that, if the scope of cases compensable is to be extended, it should be done by unambiguous legislative enactment rather than by judicial construction. For it must be recognized that if the term "injury" is to be construed to include typhoid fever contracted in the course of employment, it may as well include influenza, pneumonia, tuberculosis, smallpox, ordinary colds, rheumatism and practically every disease which may be contracted by workmen in the course of employment, and the workmen's compensation department will become a health and life insurance department for workmen, compulsorily supported by employers, and the constitutionality of the whole scheme be endangered.

*Industrial Commission vs. Cross et al., 136 N. E. 283. (This case reverses the judgment of the Ohio Court of Appeals in the case of the Industrial Commission of Ohio vs. Cross et al., an abstract of which was published in the Public Health Reports of November 11, 1921, pp 2770-2771).

Hospitals.

Overlook Hospital, Summit, and St. Barnabas' Hospital, Newark, each will receive \$15,000 from the estate of Charlotte R. Butterworth.

Camden County Tuberculosis Hospital—This hospital, now located at Ancora, will be moved to Blackwood, where a modern hospital building will be erected. This was decided after the freeholders committee had consulted experts on locations.

There are several objections to the site at Ancora. It is not high and is so far from the homes of the patients that it is not of easy access. The result was that much homesickness and loneliness among patients did them actual harm. It is also hard to keep nurses and other help at a location so inaccessible.

Monmouth Memorial Hospital—The School of Nursing of this hospital will graduate eleven nurses on March 9, Dr. A. A. Berg, of New York, will deliver the address.

Salem County Hospital—The report of Dr. James for December shows: Admissions, 40; discharges, 43; births, 7; death, 1; operations, 17; x-rays, 12. The members of the medical and surgical staff recently donated \$700 to the hospital, showing that they are not only contributing time, but money freely.

Salem County Memorial Hospital—Dr. W. H. James, secretary, reports for the month of January as follows: Admission, 60; discharges, 47; births, 15; deaths, 5; ambulance calls, 14; accidents, 22; returned for treatment, 24; patients at clinic, 49; operations, 19; x-ray calls, 14.

St. James' Hospital, Newark, Free Clinics.—Nine free clinics for indigent patients were opened at this hospital last month. Besides the regular and surgical and medical clinics there is one for children, and an eye clinic. The days on which they are open and the physicians in charge are: Surgical A Clinic, Monday, Wednesday and Friday at 11 a. m., Dr. Charles Ball; Surgical B, Tuesday, Thursday and Saturday, 11 a. m., Dr. William T. Ramage; Medical A, Monday, Wednesday and Friday, 11 a. m., Dr. J. C. Froelich; Medical B, Tuesday, Thursday and Saturday, 11 a. m., Dr. Francis Weber; Gynecological, Tuesday and Friday, 10 a. m., Dr. Royal Schaaf and Dr. E. A. Flynn; clinic for children, Monday and Friday, 11 a. m., Dr. Mancuso-Ungaro and Dr. Hunter Scott; Obstetrical, Tuesday and Friday, 3 p. m., Dr. Harry Murray; Urological, Tuesday and Thursday, 4:30 p. m., Dr. Sidney C. Keller; eye, Tuesday, 3 p. m., Dr. A. E. Zehnder and Dr. Lee Hughes.

Warren County Hospital.—The campaign to raise \$50,000 to establish this hospital has resulted in raising more than that amount.

Bonnie Burn Sanatorium.—Dr. J. E. Runnells, superintendent, reports that on January 1 there were 242 patients in the sanatorium, 141 males and 101 females. During the month twenty-seven patients have been admitted, fourteen males and thirteen females. Eight of these admissions went to the preventorium. The admissions are classified, as follows: Pretubercular, 8; incipient, 1; moderately advanced, 7; far advanced, 11. The largest number of patients present at any time during the month was 254.

Deaths.

BRICK.—At Camden, N. J., February 4, 1923, Dr. J. Coles Brick. Dr. Brick, who was sixty-one years old, had for many years devoted his time and study to the treatment of diseases of the stomach, particularly cancer. He was a brother-in-law to Professor J. Chalmers Da Costa, the noted Philadelphia surgeon, and was associated with him not only in his sanitarium, but also at Jefferson Medical College, where he was a member of the faculty until forced to resign a little over a year ago, because of his failing health.

CONDUCT.—At Dover, N. J., February 16, 1923, Dr. Arthur W. Conduct. Dr. Conduct was born in Dover, August 21, 1859. He was educated in the local schools and later entered the University of Michigan, where he studied medicine; graduating in 1882, he entered the marine hospital service. After five years spent in that service he practiced medicine first at Wharton and twenty-nine years ago opened an office in Dover. Dr. Conduct had been a member of the local Board of Education nearly a score of years, having been re-elected recently for the seventh consecutive term of three years. For nearly twenty years he was an active member of the Board of Health, retiring several years ago,

because of ill health. He was a member of Acacia Lodge No. 27, F. and A. M.; Morris Council No. 541, Royal Arcanum, and Dover Lodge No. 782, B. P. O. Elks.

DE GROFF.—At Hackensack, N. J., February 17, 1923, Dr. Ephraim De Groff, aged eighty-six years. He graduated from the University of Pennsylvania Medical School in 1863. He served as a medical officer of the Union in an army hospital in Rochester, N. Y. He was one of those who assisted in amputating the leg of Major-General Daniel Sickles at the Battle of Gettysburg.

FAISON.—At Jersey City, N. J., February 24, 1923, Dr. William F. Faison, of that city, from an attack of pneumonia. Further notice will be given next month.

LA RIEW.—In Washington, N. J., February 7, 1923, Mrs. Helen G. LaRiew, wife of Dr. Frederick J. LaRiew. She was treasurer of the local Public Library Association and active in good work.

McWILLIAM.—At Somerville, N. J., February 12, 1923, Dr. John Forsyth McWilliam, after a long illness of heart disease. Dr. McWilliam was born at Searsville, N. Y., January 31, 1860. Graduated from Rutgers College, in 1881; Jefferson Medical College, in 1883. Soon thereafter he settled in Somerville, N. J., and was engaged in active practice till failing health compelled him to relinquish his work. Dr. McWilliam served as intern in Wilkesbarre Hospital and was a veteran of the Spanish-American War. He was a member of the board of pension examiners for a number of years; was a member of Solomon Lodge, F. and A. M.; Keystone Chapter, R. A. M.; Lodge of the Castle Knights of Pythias and of the Somerset County Medical Society.

A special meeting of the Somerset County Medical Society was held at the Court House, February 13, 1923, to take action on the death of one of its members, at which the following resolutions were adopted:

"Whereas, The members of the Somerset County Medical Society have been associated for many years with Dr. John Forsyth McWilliam, and appreciate his pleasant manner, his warm-heartedness and his professional attainments. We wish to express our sorrow on the death of our highly esteemed brother.

"Resolved, That a copy of this resolution be spread upon the minutes of the society, that a copy be published in the local papers and in the Journal of the Medical Society of New Jersey and that a copy be sent to the family with whom in their loss we express our heartfelt sympathy.

"Aaron L. Stillwell, Thomas H. Flynn,
"Committee."

VOELBEL.—In Vailsburg, N. J., February 20, 1923, Dr. Benjamin W. Voelbel, aged forty-six years. Dr. Voelbel died suddenly, while driving his automobile. Further notice next month.

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ASTHMA*

By **Albert Vander Veer, Jr., M. D.,**
New York City.

In the past few years so much has been written on the theory of the causes and mechanism of asthma that I will not go into this phase of the subject in the present paper, but will endeavor to bring out some practical points in the diagnosis and treatment, which may be of value to the general practitioner, who sees a dozen or so cases during the year and is anxious to give them the benefit of the newer discoveries, but is unable to spend his entire time following this as a specialty.

In any discussion of the diagnosis and treatment of asthma by skin tests and injection of protein extracts it is common to hear opinions advanced, ranging from complete faith in its efficacy to utter disbelief in there being any value whatsoever in the method. These opinions are often based on a personal experience with, at most, a few patients, while a fair estimate can only be made from the average results obtained by a number of competent observers on hundreds or thousands of cases. When this is done it becomes quite evident that asthma is really a symptom complex arising from a number of underlying causative factors, and that certain groups of cases yield very readily to this method of diagnosis and treatment, while others prove most stubborn and frequently show no improvement. In the main it is possible to distinguish three such fairly well-defined groups. The first and largest contains those patients who show a hypersensitivity to one or more substances, usually in the so-called inhalant class. Chief among the inhalants are dust, pollens, sachets, animal epithelia, particularly feathers, cot-

ton-seed, cereals, fur dust, etc. The patients in the second (and much smaller) group give no history of hypersensitiveness and show negative reactions to all our tests. They have, however, some focus of infection located usually in the bronchi, sinuses or tonsils. The third group is a combination of these two, that is, hypersensitive patients, with a chronic focus of infection.

As the treatment and prognosis for these groups is essentially different it is of the utmost importance that our diagnosis should be correct, and I will now take up the methods by which we endeavor to arrive at a proper solution of the problem. A careful history is absolutely necessary. This should include the question of inheritance, age of onset, occupation, seasonal occurrence, description of original and later attacks, association with eczema, migraine, hypersensitiveness to certain foods or drugs, presence or absence of pets in the house, the kind of pillows, mattresses and stuffed furniture used, occurrence of **asthma in certain environments** or houses, whether attacks come by day or night, or while performing certain duties, such as cooking or house cleaning, whether the original bronchitis and asthma followed an acute infection, as grippe or pneumonia, and lastly whether the symptoms resemble true bronchial asthma or are those of a cardiac or renal type.

Let us take up each one of these points in detail and show why it is of importance in assigning the case to its proper group and what bearing it may have on treatment.

First of all the question of inheritance and age of onset: It was shown many years ago that true hypersensitiveness was (in most cases) inherited, and that the more direct the inheritance the earlier would the symptoms appear. For instance, if a child of five is brought to us suffering

*Paper read before the Morris County Medical Society, December 12, 1922.

from asthma and with a family history that the father has hay fever and the mother cannot eat shell fish, we may be reasonably sure that the child belongs in group one and will show a hypersensitiveness to feathers, dust or some other of the inhalant group, or possibly to milk, eggs or some of the foods. The latter suspicion is strengthened if the asthma is associated with eczema or gastro intestinal disturbances. Conversely, if the first appearance of the trouble is at fifty and there is no family history of hypersensitiveness we should suspect the presence of an infective focus and bend all our efforts to its discovery and eradication.

Occupation.—There are certain well-known occupational asthmas, the best-known being that occurring among bakers and furworkers. Equally important, but less often recognized is asthma among housewives, due to house dust or to cereals used in cooking. It is important to know not only the occupation of the patient, but of the other members of the family. We have had several cases of asthma in women, due to hypersensitiveness to horse epithelium, where the husbands were working around horses and the exposure came from the clothes worn home from work, although the patients themselves never went near a stable and never came in contact with horses. Similar conditions might obtain with the wives of bakers and fur workers.

Seasonal Occurrences.—Where the attacks are limited to a definite season of the year it is reasonable to infer that the patient is exposed to the exciting cause only at that time. If this is in the summer we naturally think of a pollen; tree pollens in the early spring, grass pollen in June and July, and rag-weed in August and September. In the latter case the asthma may be prolonged into the fall and winter, even when the rag-weed has disappeared, the continuation being due to secondary bacterial infection. Freedom in the summer time, with occurrence only in the winter may point to bacterial infection at a time when resistance is lowered by exposure.

A careful and accurate description of the earliest and later attacks frequently throws light on the cause of the trouble. In some infants, hypersensitive to milk or eggs, there may be a sudden alarming explosion, with vomiting, diarrhea, asthma and urticaria the very first time they receive the slightest amount of such food. Here the diagnosis is easy, but in other cases

where the hypersensitiveness is less acute it may be several weeks or months, after the change of diet, before the appearance of eczema and an increasing number of attacks of asthmatic bronchitis lead to the suspicion that all is not well, which suspicion becomes a certainty when a sudden, acute attack of frank asthma leads to a more careful study of the condition. Another illustration of the importance of a history of the earlier attacks, but in quite a different class of cases, is that given by Rackeman, of Boston. He traced the gradual development of some of his asthma cases, first occurring only with hay fever in August and September, gradually prolonged into November and December, and finally ending up in chronic asthma lasting all through the year. Here the importance of the pollen element would be entirely masked by the perennial aspect of the case without a careful history of the early attacks.

The association of asthma with eczema has already been touched on and is chiefly important in children. In this connection it may be well to mention the danger of forcing children to eat foods to which they show a distinct aversion, as this is often protective and means that the child unconsciously realizes that such food does not agree with him. I do not refer to the natural preference for candy and sweets, taken to the exclusion of more wholesome food, but where a diet is well chosen and yet the child must be forced to take such a normal food, as milk, we often find that he will eat better and gain in weight and strength if the milk is omitted. In adults hypersensitiveness to foods is much rarer than is commonly supposed. At forty we have usually learned what does and does not agree with us and have chosen our diet better than most doctors could do. Over-indulgence in food will often bring on an attack in any asthmatic; but it is the quantity and not the particular kind of food that is at fault. Nuts and shell fish are more apt to cause trouble than any other articles of diet.

Hypersensitiveness to cats and dogs is relatively common and their presence or absence in the house should be ascertained. It is not necessary to prove actual contact with the animal, as they shed their epithelium all over the house and it is later breathed in with the dust, so they may be a source of continual trouble without ever being seen by the patient. It is in this class of cases that we occasionally see our most brilliant

results; for if the hypersensitiveness is limited to dog or cat epithelium alone the mere removal of the animal, with a thorough house cleaning, will give instant and complete relief. Unfortunately the hypersensitiveness is usually multiple and there are other sources of trouble which must be removed.

Analogous to the presence of pets in the house is the use of feathers and animal epithelium, as rabbit and goat hair, for pillow furniture stuffing. We, most of us, sleep on feather pollows and it is surprising the amount of rabbit hair used in upholstery and mattresses. If we find that a single cat or dog in a house may cause continual trouble it is easy to see that several sofa pillows or a large mattress may be of equal or greater importance. Here again it is essential to make the patient realize that it is the dust from these articles, mingling with the house dust, that causes the trouble, and that he is not safe merely because he does not happen to sleep on the pillow or mattress in question.

We often learn that the attacks of asthma occur only in a certain environment, and this proves of great help in finding the cause. A baker may complain of trouble only when in his shop, and frequently we have a history of attacks only when the patient goes to a certain house, being entirely free at other times. The patient usually attributes this to a difference in altitude or degree of dampness, but, as a matter of fact, it is due to some particular substance met with only in that environment. The furnishings in one house may be much the same as in others, but the addition of a dusty feather bed or down comforter or a few rabbit hair pillows may make one bedroom quite unsuited for an asthmatic, while another, apparently the same, may prove entirely harmless. Where the attacks occur only at home and at night it is reasonable to direct our investigation at first to the bedroom, particularly the pillows and mattress, but we must bear in mind that asthma, from any cause, is usually worse at night and thus our search cannot be confined to the bedroom alone.

With the patients of group two it is often significant to note that the asthma developed, after an acute infection, as grippe or pneumonia. It is usually preceded by a bronchitis for a few weeks or months, with the gradual onset of wheezing and dyspnea and finally distinct asthma. In these cases the condition rarely clears up entirely; for between attacks there is a

chronic bronchitis, less in summer, more pronounced in winter, with occasional exacerbations or fresh infections. Sputum cultures often show the original infecting organism, and vaccines made from such cultures frequently prove of benefit.

Cardiac and renal asthma must be ruled out by the history and physical examination. Dyspnea only on exertion, with the occurrence of oedema of the face or ankles, coupled with headache and dizziness, is at once suggestive that we have to deal with a circulatory disturbance and not with true bronchial asthma. Tuberculosis must also be born in mind, as the two conditions not infrequently occur together. While it is common to see some loss of weight in asthma and rarely blood-tinged sputum we do not get temperature, except in the last stages of a chronic bronchitis or in the occasional attacks of acute reinfections. The x-ray and frequent sputum examinations are of help in the differential diagnosis.

A thorough physical examination should follow the history, particular stress being laid on the condition of the nose and accessory sinuses, tonsils, teeth, presence or absence of an enlarged thymus (in children), signs of hyperthyroidism, condition of the heart and lungs, blood pressure, and a urine and sputum examination. The importance of each of these examinations has already been explained, under the history, or will be gone into with greater detail in the remarks on treatment.

The patient should now be tested out with all substances with which he may come in contact, either by inhalation or ingestion. The method of performing such skin tests has been so thoroughly discussed that I will not go into detail, but will mention some of the points, which are of importance in obtaining the best and most accurate results. The intradermal method is more delicate than the so-called scratch method, and the extracts prepared, according to the directions outlined by Dr. Arthur F. Coça, in the March, 1922, Journal of Immunology, give better results than the ordinary commercial preparations. The greatest stress should be laid on having a large and varied assortment of the inhalants, and tests with the food extracts are of relatively little importance, except in children. We often see patients who say they have been completely tested out with negative results, where a careful check up reveals they have had fifteen or twenty food tests, with but four or five of the really

important inhalants. This kind of work tends to bring the whole method into disrepute, as the average patient is unable to judge of the relative importance of one method of testing over another, and the fact that he has had skin tests and they were negative makes him averse to any more trials along the same line. Mention has been made of the more important inhalants, but it will not be a waste of time to repeat them here. Extracts of house dust react more frequently than any other substance, next in importance being feathers and other animal epithelia, pollens, sachets, cotton, wool and silk, insecticides, cereals and many occupational dusts.

It is possible to do about fifteen or twenty of these tests at each visit, putting in six at a time and then waiting ten or fifteen minutes to avoid the danger of getting several positive reactions at one time. The first tests with the pollens, horse serum and epithelium, cotton and flaxseed, and a few of the other substances must be done with very weak solutions to avoid the danger of a constitutional reaction, which may occur in very sensitive people, even from a skin test. A constitutional reaction manifests itself as a sudden general urticaria, with asthma and swelling of the mucus membrane of the eyes and nose, and while they rarely occur if proper dilutions are used they are so disagreeable that they must be guarded against in every possible way. As a rule, they can be instantly controlled by a hypodermic injection of 6-10 to 8-10 cc. of adrenalin chloride, repeated in five to ten minutes if necessary. No tests or injections of protein extracts should ever be given, unless the physician has some adrenalin chloride at hand in case a constitutional reaction develops.

The complete group of inhalants can be done, with retests, in three or four visits, while the food tests take three or four more. We rarely find people sensitive to a single substance, and, therefore, the tests should be completed, as removal of but one factor where there are several more will not clear up the trouble. If facilities are not at hand for such complete testing it is often more satisfactory to send the patient where it can be done, and after the diagnosis has been made the family physician can carry out the details of removing offending substances and supervising conditions at home more intelligently and successfully than anyone else.

The accuracy of the skin tests varies considerably with the different substances.

In general, we may say that the results of tests with the inhalant group are 90 to 100 per cent. correct, with the foods 50 per cent. correct, and with the bacterial proteins useless. If an inhalant gives a marked positive reaction it will repeat that reaction every time it is tested on the same patient, and is almost invariably a cause for trouble if the patient comes in contact with that substance. Food extracts will often give conflicting results, when tested at different times, and will often disagree absolutely with the clinical history. With bacterial proteins we were never able to demonstrate that they gave us any information as to the infecting organism and have long since given up their use entirely.

When a diagnosis has been established, as accurately as possible by the means at our command, by careful history, physical examination and tests, the treatment can be concisely stated in three words, common sense and patience. Remove from the patient's environment every source of trouble that can be removed and immunize him against such as cannot be otherwise controlled. Eradicate by thorough and competent surgical measures all sources of chronic infection, which can be eradicated. Supplement such procedures by injections of vaccines, made from the patient's own sputum, sinus discharges or tonsil cultures, when the tonsils are removed. Such vaccines must be properly made by a competent bacteriologist or they will prove useless. Except in rare cases, do not expect the favorable results to be immediate and permanent. Improvement, however, is often evident in a surprisingly short time and may be shown in the most hopeless cases.

It may be of value to say a few words more in detail as to the treatment of the various groups. X-ray therapy in children, with an enlarged thymus, is usually very successful, as is also x-ray treatment of an enlarged thyroid, combined with removal of infected tonsils where present. In our cases x-ray treatment of infected tonsils has proved disappointing, and their removal surgically is necessary. Pollen asthma should be treated by injections of pollen extract, which yields successful results in about 80 per cent. of the cases. This also protects the patient from the danger of developing a chronic perennial asthma later. Immunization, with extract of horse epithelium in horse sensitive cases, is also very satisfactory, but we have had little experience with using dog or cat epithelium, as it

is much simpler to avoid exposure to such animals.

With bakers and fur workers it should theoretically be very easy to produce an immunity by injections of cereal or dust extract, but in practice this is not the case, and it is often necessary for the patient to change his employment. While this is a hardship it is usually followed by complete relief from the asthma.

In cases sensitive to feather dust and house dust it is usually possible to afford relief by the proper selection of silk floss or cotton pillows and mattresses, elimination of all feathers from the house, and active immunization by injections of extract of house dust. The most difficult part of this problem is to get the patient and his family to realize the importance of following out instructions, and it is frequently necessary to make several personal inspections of the home to be sure that directions are being carried out.

The least satisfactory results are obtained with patients in group two, where we have to deal with a chronic infection and not with a hypersensitiveness, as we now understand it. It is here that our patience is taxed to the limit and that we have need of the very best help that surgery and bacteriology can furnish us. Even here, however, it is surprising what good results can be obtained, and while only a small percentage can be entirely and permanently relieved, the majority can be brought to a state of comparative comfort and can usually take up their work again with little disability.

As we look on the problem in its entirety we cannot help but feel encouraged at the advances which have been made in the last ten years and particularly in the fact that we are now able to diagnose and treat many cases, while they are still in group one, and thus clear them up before they contract local infections and graduate into group three, where the chronically congested and infected tissues have less chance to return to normal.

An Error in Calculation.—Host (to guest, a retired doctor)—And did you ever make a serious mistake in your diagnosis?

Guest—Yes, one serious one—I once treated a patient for indigestion and she could easily have afforded appendicitis!—The Passing Show (London).

Accomplished.—"Everybody should lie on the right side," is the advice of a medical man. The only exception, we gather, is the politician, who can do it on both sides.—Punch (London).

THE CORRECTION OF NASAL DEFORMITIES ASSOCIATED WITH HARELIP AND CLEFT PALATE*

By Warren B. Davis, M. D.
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All cases of harelip, whether partial or complete, and those cases of cleft palate in which the cleft involves the alveolar process unilaterally or bilaterally, present nasal deformities which require special care in anatomic considerations and in detail of operative treatment, if good functional and cosmetic results are to be secured.

The deformities observed are widening of the nostril, with corresponding flattening of the ala nasi, deviation of the nasal septum, elongation of the septum, especially in cases showing anterior displacement, with antero-superior rotation of the premaxilla, and shortening of the columella. The extent and types of nasal deformities vary, in accord with the degrees of the clefts. We shall illustrate several of the types by some photographic records selected from our series, and shall consider the combination of methods we have found most satisfactory in correcting each type. (For the privilege of operating upon many of the cases in this series, I am indebted to Dr. J. Chalmers Da Costa, on whose service at Jefferson Hospital I have done this work since 1915).

Incomplete Unilateral Harelip Without Cleft Palate.—Even if the cleft in the lip



FIG. 1.—Case 1. Aged five months. Incomplete unilateral harelip, showing scantiness of muscle tissue in the upper portion of the lip, between the angle of the cleft and the floor of the nostril, with consequent widening of the nostril, flattening of the ala nasi and moderate deviation of the nasal septum.

*Paper read before the Rhinological Section of the Academy of Medicine of Northern New Jersey, January 8, 1923.

be little more than an indentation (Figure 1) examination shows that between the superior angle of the cleft and the floor of the nostril there is an absence of muscle tissue, and only a small amount of connective tissue between the skin and the mucous membrane surfaces of the lip. The absence of muscle tissue allows lateral displacement and flattening of the ala nasi, with consequent widening of the nostril. The anterior portion of the nasal septum shows some degree of deviation toward the opposite side.

The deformities are preferably corrected in early infancy. Early accurate approximation secures not only better contour of nostril and less deviation of the septum (Figure 2), but also obtains better de-



FIG. 2.—Case 1. Showing nasal contour eleven weeks after operation.

velopment of the muscles in the lip. There is consequently more nearly normal function in expression, as shown, especially when the individual smiles or laughs.

The incomplete cleft should be converted by the first step of the operation into a complete one, the incisions extending upward through the floor of the nostril to allow thorough approximation of the separated muscle tissue in the lip and also permitting the ala nasi to be brought into proper anatomic relationship. Outlining the incisions found to be most satisfactory is probably best done by the method of J. E. Thompson (Figure 3). The lip is then freed well from the anterior portion of the maxilla to allow the ala nasi to be brought medially the desired distance. The deviated nasal septum is forced toward the median line by means of a Sinexon nasal dilator. Slight over-correction is advisable when placing the highest suture approximating the ala nasi and the tissues at the base of the nasal septum. In making this

approximation most cases also require some elevation of the infero-lateral alar margin to secure symmetry with the opposite side. We use fine catgut sutures in

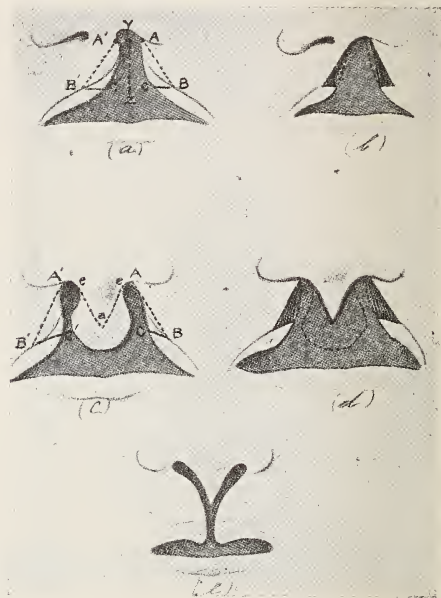


FIG. 3.—Semi-diagrammatic sketches, showing lines of incisions used for the correction of single and double harelip. (After methods of J. E. Thompson.) In single clefts (a) sharp-pointed calipers are used in measuring the distance (YZ) from the mid-point of the floor of the nostril to the point in the same sagittal plane to which the free margin of the lip would come if it were of normal contour. Fixing the distance on the calipers and keeping the superior point at Y, the inferior point of the calipers is rotated describing an arc which crosses the vermillion border of the lip on each side of the cleft. These points B and B' are distinctly marked by making a puncture with the point of the calipers or with a small scalpel. Point C and C' are then located on the free margin of the lip so that the angles ABC and A'B'C' are between 70 and 80 degrees. Incisions carried through the entire thickness of the lip with a small scalpel at a right angle to the skin surface and following the lines as outlined will give surfaces for approximation which are of equal length and which, when sutured together, will give a lip the length of which is the estimated normal length (YZ) plus the distance from the vermillion border to the free edge of lip (CB) which is usually just sufficient to allow for subsequent contraction. Sketch b shows tissue removed. Lines of incision used in double-harelip are shown in sketch c. The philtrum is trimmed to a V-shape, leaving as much tissue as is possible with thorough removal of the vermillion borders. The lateral incision lines are outlined as described for single-harelip. Sketches d and e show tissues ready for approximation.

approximating the muscle tissue and also on the mucous membrane surface. Fine black silk sutures, alternating with horse-hair, are used on the skin surface and at the free edge of the lip.

Complete Unilateral Harelip.—(Figure 4) shows a more marked degree of the above described deformities. The manner of correction is practically the same, since the incomplete cases are made into complete ones by the first step of the operation. Operative result is shown in Figure 5.

Complete Unilateral Harelip and Cleft

Palate is accompanied by marked flattening of the ala nasi, deviation of the nasal septum to the opposite side, anterior displace-

a green-stick fracture at the point of partial division, when the premaxilla is forced into position. The margins of the alveolar cleft



FIG. 4.—Case 2. Age twelve months, showing unilateral harelip, deviation of nasal septum and moderate flattening of ala nasi.

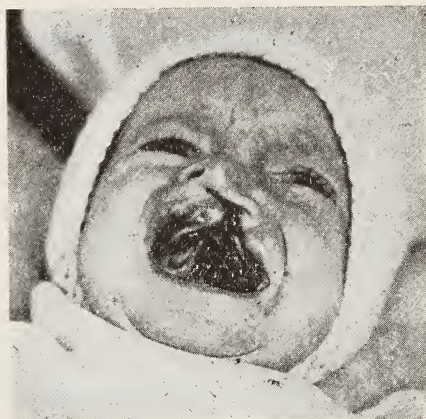


FIG. 6.—Case 3. Showing well the deformities associated with complete unilateral harelip and cleft palate.



FIG. 5.—Case 2. Showing nasal contour eighteen months after operation.

ments and partial rotation of the premaxilla. (Figure 6).

We usually reconstruct the alveolar arch and repair the nasal and lip defects at one operation, leaving the cleft remaining posterior to the alveolar arch untouched until a subsequent operation a few months later.

When the alveolar cleft is narrow and the patient is quite young, the alveolar margins may be approximated by digital pressure, supplemented by pressure against the lower portion of the nasal septum and the floor of the nostril by means of a small nasal dilator. In older cases, or when the separation is wide, even in infants, it is often necessary to partially divide the alveolar process on its buccal surface—just posterior to the canine area. This allows

are held in position by a silver wire, applied as shown in Figure 7. This procedure not only closes the alveolar cleft, but by bringing the premaxilla into nearly normal position, the deviation of the nasal septum is corrected and the width of the cleft in the lip is greatly reduced. The plan of repair of the lip and nostril is then essentially the same as described above, but requiring more extensive separation of the lip from the anterior portion of each maxilla. It is often advisable to use a shotted stay suture to relieve tension on the

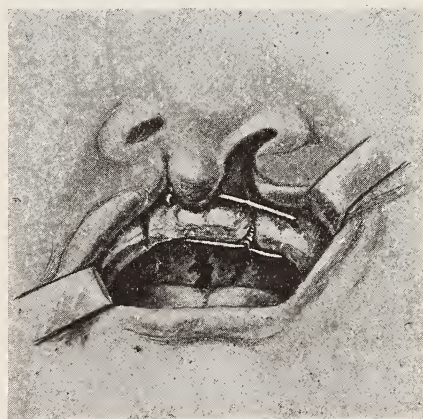


FIG. 7.—Sketch showing partial deviation of alveolar process on right side, just posterior to canine region. The mucous membrane has been removed from the margins of the cleft in the alveolar process to secure raw surfaces for approximation, which has been made by combined inferolateral pressure on the premaxilla and on the lower portion of the nasal septum by Sinexon's nasal dilator. Silver wire is tightened, while parts are held in position. This closes the cleft in the alveolar arch and decreases the nasal deformity.

suture line and to aid in keeping the lateral portion of the alar cartilage in its proper relation to the base of the septum. Case IV (Figure 8) was treated by this method. Result is shown in Figure 9.



FIG. 8.—Case 4. Age four weeks. Complete unilateral harelip and cleft palate. Moderate rotation of premaxilla.



FIG. 9.—Case 4. Showing condition five months after operation.

Complete Bilateral Harelip and Cleft Palate cases show varying degrees of antero-superior rotation of the premaxilla, elongation of the vomer and the nasal cartilage, shortening of the columella and the philtrum, and flattening of both alar cartilages (Figure 10). Some cases also have lateral rotation of the premaxilla and an associated deviation of the septum. If there is marked antero-superior rotation of the premaxilla it is advisable to remove submucously a triangular section of the anterior portion of the vomer and nasal cartilage of just sufficient size to permit infero-posterior rotation of the premaxilla to its normal position (Figure 11). The base of the triangle removed should be equal to the arc through which the premaxilla is

to be rotated. The incision for the submucous removal is made in the midline on



FIG. 10.—Case 5. Age two months, showing complete bilateral harelip and cleft palate, with marked elongation of the vomer and antero-superior rotation of premaxilla. Note absence of columella and the philtrum extending directly anteriorly from the tip of nose.

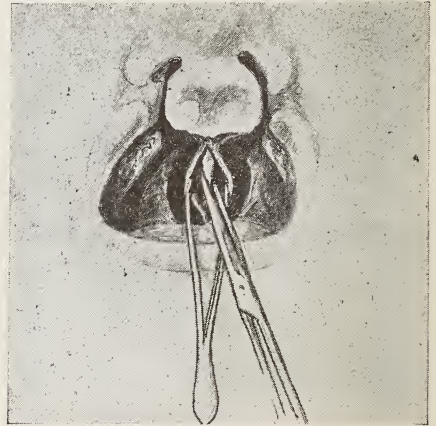


FIG. 11.—Sketch showing submucous removal of a triangular section, from the vomer and nasal cartilage, just posterior to the premaxilla.

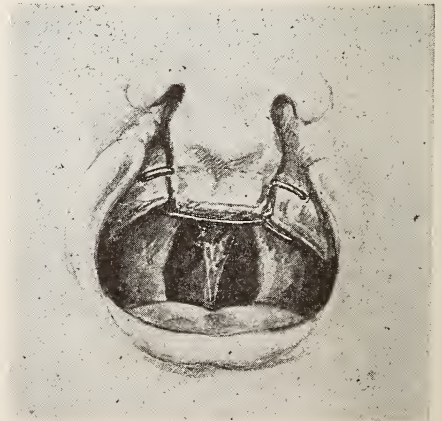


FIG. 12.—Showing premaxilla rotated into normal position and held by silver wire sutures.

the lower surface of the vomer, just posterior to the premaxilla. If the abnormal increase in the length of the vomer is greater than is corrected by the triangular resection, then a rectangular section is removed more posteriorly, the antero-posterior extent of the section being just sufficient to allow the premaxilla to be forced posteriorly into position to form as nearly a normal alveolar arch as can be constructed (Figure 12). The lip and the anterior por-

antero-superior rotation of the premaxilla, all deformities were corrected at one operation.



FIG. 13.—Case 5. Showing nasal contour, after first operation, in which the premaxilla was rotated into position to complete alveolar arch, after submucous resection of a triangular section of the vomer and nasal cartilage.



FIG. 15.—Case 6. Age six weeks. Bilateral harelip and bilateral clefts in alveolar process, but not extending into the horizontal portion of palate, showing antero-superior rotation of premaxilla and shortness of the columella.



FIG. 16.—Case 6. Showing the well-formed palate posterior to the area normally occupied by the premaxilla. Note elongation of vomer.



FIG. 14.—Case 5. Showing nasal contour one month after second operation.

tions of the cheeks are well freed from the antero-lateral surfaces of the maxillae, thus allowing sufficient relaxation to permit the alae being brought medially to form symmetric nostrils of the desired width. Extensive deformities sometimes require a two-stage operation for the anterior work. Case V (Figures 10, 13 and 14) was treated in that manner. In Case VI (Figures 15 and 17) double-harelip and bilateral clefts, through the alveolar process, with marked



FIG. 17.—Case 6. Showing nasal contour sixteen days after operation.

While all of these types of nasal defects are preferably corrected in infancy or early childhood, yet much can be done to improve them in adults who have not had operations, or more frequently in those who have gotten poor results from early operations. In the case shown in Figures 18-20 there was a complete unilateral cleft of lip

because of the excess width and thickness of alar fold. Results are shown in Figure 20. The wide excess scar tissue previously in the lip had precluded the possibility of successfully growing a mustache. The present growth leaves very little of the smaller scar visible.

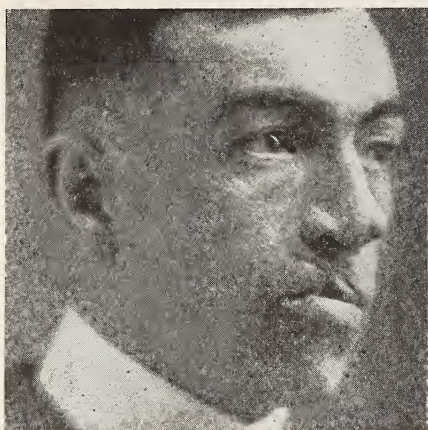


FIG. 18.—Case 7. Age thirty-two years. Showing poor result of harelip operation done in early childhood.

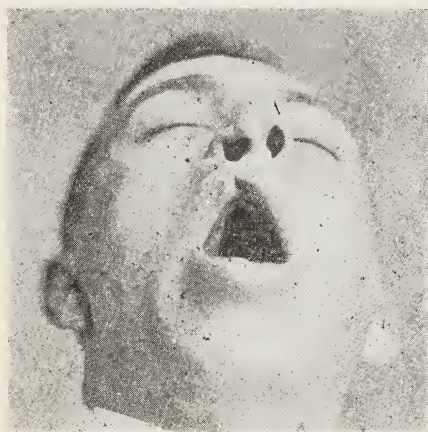


FIG. 19.—Case 7. Showing poor result of harelip and cleft palate; operation done in early childhood. Note deformity of alar cartilage.

and palate, in which the operations on the palate in early childhood were failures and those on the lip very poor successes. At our first operation the lip was completely redivided, much of the old scar tissue removed, the lip and ala were extensively freed from the maxilla and reapproximated in better alignment. One month later, when the cleft in the palate was being closed, some additional work was also done on the alar cartilage—removing intranasally two small triangular sections of cartilage at points where there were undue angulations,

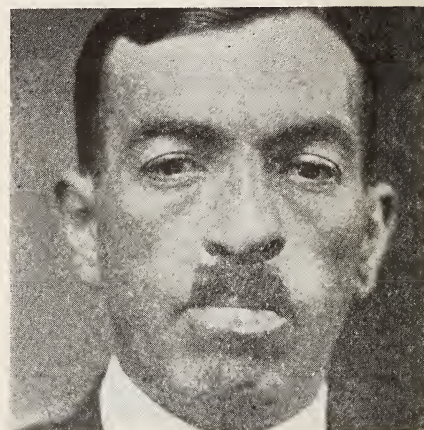


FIG. 20.—Case 7. Showing nasal contour two months after second operation.

In two other young adults showing poor results of operations done in early childhood for unilateral harelip and cleft palate, the lateral displacement of the entire anterior portion of the nose, in each case, was as disfiguring as was the poorly reconstructed lip and nostril.

On each of these cases the operative work was done in three stages: First, the lip was accurately measured and incisions outlined (Thompson method) to definitely secure a lip of proper length. Complete division of the lip into the floor of the nostril and freeing the lip and the anterior portion of the cheek from the maxilla, allowed reconstruction of the lip and the nostril on better anatomic lines—as described in primary harelip operation. Second Stage: The cleft in the palate was repaired after an interval of two months. Thirdly, after another period of two months the lateral deviation of the nose was corrected, as follows:

The lip was elevated and a transverse incision made over the base of the nasal septum, just above the alveolar process. The mucoperiosteum was then separated from each side of the inferior portion of the septum, carrying the separation posteriorly approximately one and three-quarter inches. The septum was then divided, just above the floor of the nostril, with a narrow chisel, the division being carried posteriorly almost as far as the mucoperi-

osteum had been separated. This allowed the septum and with it the entire anterior portion of the nose to be placed nearer the normal position and held in the desired



FIG. 21.—Case 8. Age sixteen years. Showing poor result of harelip; operation done in early childhood. Note deviation of all nasal structures toward the opposite side.



FIG. 22.—Case 8. Note contour of nostrils and nasal deviation.



FIG. 23.—Case 8. Showing nasal contour seven months after Figure 21.

location by the small amount of overlapping of the edges of the divided vomer, supplemented by moderate pressure from a nasal pack. The results of this procedure (Figures 21-23) gave distinct improvement in facial symmetry and also in nasal respiration. The improvement in disposition, in mental attitude and in general outlook on life has been as marked in both of these cases as has been the physical change, and the sincere expressions of appreciation by the patients and by their relatives encourage us to use this method more frequently in other similar adult cases.

OBSERVATIONS IN THE TREATMENT OF PULMONARY HEMORRHAGES BY ARTIFICIAL PNEUMOTHORAX*

By **M. James Fine, M. D.**

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I am aware that this subject has been brought to your attention before, and through iteration and reiteration has lost a good deal of its novelty, yet, because of its practical importance, it may be interesting to you to analyze the findings of individual observers at the last analysis. Knowledge can only be accumulated and established through the means of the findings of the individuals.

It is a well-known fact that mechanical pressure outside the lungs will stop a hemorrhage more effectively than treatment with medicine. Equally effective mechanical pressure is obtained by an injection of air into the pleura. This causes a partial collapse of the effected lung. As I shall show later, it is not always possible to determine exactly the seat of the hemorrhage before proceeding with the induction of an artificial pneumothorax, but it is well to remember that in cases well advanced, when the lungs are usually filled with blood, a great number of gurgling rales can be heard, which are usually more pronounced on the side where the hemorrhage is located. Very seldom does bleeding take place from both sides at the same time.

I am convinced that, after an injection of air, the development of a hydro-pneu-

*Read before the Clinical Section of the Eighteenth Annual Meeting of the National Tuberculosis Association, Washington, D. C., May 5, 1922.

mothorax is not especially detrimental, and I dare say a slight hydro-pneumothorax, which usually does occur in this work, is desirable. The lung is maintained in a collapsed condition, the hemorrhage invariably ceases and, if no infection develops, there is nothing disadvantageous in this condition. Furthermore, in febrile cases, where the patient insists upon being active and refuses the rest treatment, I have noticed that the induction of an artificial pneumothorax will effectively stop the hemorrhage and permit the patient to be about.

In afebrile cases it is frequently claimed that hemorrhages are rarely fatal, but in my experience I have seen such cases where complete exsanguination resulted. I, therefore, suggest that in cases of hemorrhage, no matter how grave or slight, if the usual medication does not result in its stoppage, an artificial pneumothorax should be induced. I wish to state at this point that one induction of an artificial pneumothorax has almost always resulted in completely checking the hemorrhage, and very rarely did I have to resort to a second induction.

I have seen patients where exact diagnosis was impossible, and where the exact location of the hemorrhage could not be determined. In such cases, I found that the induction of an artificial pneumothorax was of decided benefit, even when the pressure was exerted on the opposite side from which the bleeding occurred, for in such cases, it would seem, the pneumothorax exerts a material pressure indirectly through the lung tissue on the opposite side. Even in cases gravely advanced, where extensive cavitation and ulceration have taken place bilaterally, an induction of an artificial pneumothorax, with its resulting mechanical pressure, will check the hemorrhage. This procedure may cause the collapse of this cavity, and thereby give the lung an opportunity to heal. It must, of course, be admitted that sometimes in such cases the hemorrhage will cease, and yet the progress of the disease may continue and the patient will eventually die.

I wish to say a few words with regard to the induction of an artificial pneumothorax in patients, where pleural adhesion has taken place. It is sometimes claimed that the induction of a pneumothorax in such cases is undesirable. In my own experience, I have had cases with pleural adhesions, where I was at first unable to induce an artificial pneumothorax; but after

finding a location, which was free from adhesions, I had succeeded in inducing air in the pleural cavity, and, as in all other cases, the resulting mechanical pressure effectually stopping the hemorrhage. In other words, I hold that the induction of an artificial pneumothorax should not be abandoned in these cases. Repeated attempts should be made. Furthermore, very recent pleural adhesions may gradually give way to the pressure.

With regard to the quantity of air to be injected, I have observed that the wisest course is to give the minimum quantity. Especially is this rule to be observed in gravely advanced cases and where there is a possibility of effecting a spontaneous pneumothorax on the healthy side. I have found that 300 cc. of air is the maximum desirable amount. In Case 10, for instance, had administered 300 cc., as usual, the life of the patient would probably have been prolonged.

I wish to conclude with the statement that in only one case, which I administered air to induce an artificial pneumothorax, have I noted an unfavorable sequel. This good fortune I attribute to the wholly beneficial effect that the induction of an artificial pneumothorax exerts. A highly nervous patient, where a collapse of the lung is indicated will often refuse an artificial pneumothorax in fear that he will become worse. When, however, a hemorrhage results he will permit the physician to do almost anything in an attempt to stop the bleeding. If the first injection has been successful the confidence of the patient is gained, and he will permit the continued application of this treatment, as a curative measure.

From the cases which have come under my observation I have selected the following to best illustrate the views I have expressed above:

Case 1. An electrician, American, age forty, sick three years, expectorated about one dram of blood every morning; never thought he was ill; sputum negative for two and one-half years lesion was located on the right side, involving the entire upper lobe. I gave him 150 cc. of air, bleeding stopped. Seven days later, when I attempted to refill, I found that he had developed a hydrothorax. Medicine had no effect on the bleeding.

Case 2. An American school teacher, age thirty-one, who had tuberculosis for about two years. Lesion involved both species; the left being more active. Patient

first developed a hemorrhage, when out of bed, and insisted upon going about and being active; 350 cc. of air was given on the left side; bleeding stopped. I kept up the air twice a week for curative purposes.

Case 3. A Russian garment worker, sixty-five years old; brought to the hospital while having a hemorrhage. It was very profuse and alarming; medicine had no effect. It was impossible to make out the condition of the chest, from the examination. There were a great many gurgling rales over both chests. I gave him 300 cc. of air on the left side. Bleeding immediately stopped. Two days later streaks of blood appeared in the sputum. I gave him another injection of 350 cc. in the same side. There was no more bleeding; patient was sent to the sanatorium for advanced tuberculosis, but refused to stay, returning home. At present is feeling fine.

Case 4. An Italian banker, forty-two years old; patient's first symptom was a severe hemorrhage; he never knew he had any trouble; lost about an ounce of blood at first and continued bleeding; medicine had no effect. Chest was filled with blood, and it was impossible to make out the exact lesion, but on examination more gurgling rales were found on the right side. I injected 300 cc. of the air in the right side; the hemorrhage stopped, but again it started three days later; I gave him 400 cc. and bleeding entirely stopped; condition was bilateral, but more extensively on the right side. His condition since has improved a great deal.

Case 5. Russian glass-blower, thirty-three years old, has been in hospital five weeks; came in with a tuberculous pneumonia. Patient's general appearance was good; condition of chest showed a moderately advanced lesion, which extended over the entire right side and the apex on the left; he was bleeding for two days, quite extensively; usual treatment was of no avail. I gave him 350 cc. on the right side; bleeding stopped. When sent to the sanatorium he had occasional streaks of blood. Expectoration, though, was profuse.

Case 6. An Italian laborer, age twenty-four, came to the hospital, with a hemorrhage, expectorating about one dram of blood every hour. The next day the hemorrhage was more severe. The lesion was confined to both species. I attempted to induce air on the right side posteriorly, but could not succeed in getting into the pleural cavity, because of a thickened pleura. Two days later the hemorrhage became very much worse. I attempted to inject air

anteriorly on the right side and succeeded in getting in. I gave him 300 cc. Bleeding stopped immediately.

Case 7. An ex-soldier, twenty-three years old chest condition quite advanced; had been under regular treatment about four years. Lesion very extensive on right side and left apex. Started to bleed; I gave him 350 cc. of air in the right side; bleeding stopped; continued with this treatment twice weekly for about three months; patient got along very nicely for about a year, but now his condition is much worse.

Case 8. Austrian laborer, age forty, had been sick for two years; admitted to hospital in a moribund condition; lesion in chest advanced; cavitation in right side and extensive ulceration on left side; while in bed, with a high fever, he developed a hemorrhage. I gave him 300 cc.; patient stopped bleeding; condition gradually became worse, and a month later he died.

Case 9. An American, factory hand, age thirty-two years; came to hospital expectorating about three ounces of blood every morning; the onset of his condition was about three months previously; he then had a hemorrhage of one-half cup of blood; lesion in chest confined entirely to right side. While in the hospital the hemorrhages became more severe. I gave him 500 cc.; the hemorrhage stopped, but he continued to have streaks of blood in his sputum. A month later he had another hemorrhage. I gave him again 500 cc. of air; bleeding stopped, but streaks occasionally appeared in sputum. Two weeks later he had another hemorrhage; I gave him 800 cc. of air. A week later patient was sent to a sanatorium; there was no blood in sputum.

Case 10. An Italian-American cloak operator, twenty years old; patient sick about three years; brought to hospital in dying condition; both lungs literally shot to pieces; patient expectorating a great deal of blood. I knew that he could not be saved, but thought I might prolong his life. I gave him 1,200 cc. of air; the hemorrhage stopped; the patient felt better; a few hours later the patient complained of a pain in his chest, which had come on suddenly, followed by dyspnoea, and in a few minutes the patient died. Death was probably due to spontaneous pneumothorax on the opposite side.

SUMMARY.

1. Artificial pneumothorax has been more effective in its control of pulmonary hemorrhage than any medical treatment.

2. Though it is seldom that bleeding oc-

curs from both lungs, the side having rales most pronounced is usually the offending side.

3. Development of a hydro-pneumothorax without a complicating infection is not detrimental and may be desirable.

4. Febrile cases, with hemorrhage, can be managed to such an extent that allows the patient, who refuses rest treatment, to be up and about.

5. One induction usually suffices.

6. Repeated attempts should be made in those cases of thickened and adhesive pleura to induce an artificial pneumothorax. They have proven beneficial in my experience.

7. A minimum quantity of air is all that is necessary. About 300 cc. is the maximum quantity in most cases.

362 Clinton avenue.

SOME NEWER METHODS OF INFANT FEEDING*

By **Harold R. Mixsell, M.D.,**

New York City.

Introduction—In speaking to a mixed audience of doctors it is usually rather hard to find any one subject which will interest them all. However, even the surgeon encounters difficult feeding cases, and certainly a large amount of the general practitioner's work is among children. For this reason I have chosen as my topic tonight "Some Newer Methods of Infant Feeding," in the hope that I may be able to elucidate a few methods of feeding difficult cases in vogue at the New York Nursery and Child's Hospital, New York city, and in my own private practice. In this connection, let me add that we still rely on breast milk and whole milk dilutions to a major degree, and that it is only in cases that will not do well on these do we experimentally try these other methods. In so doing we recognize the fact that infant feeding is an art and not an exact science and that one must adapt oneself to the individual child.

Accordingly, I will take up in order the following subheads:

1. Thick cereal feeding.
2. Czerny Kleinschmidt buttermeal mixture.
3. Whole lactic acid milk—Karo syrup.
4. Eiweiss-milch.
5. Casec, Larosan.
6. S. M. A. Gerstenberger.
7. Dryco and other dried milks.

1. *Thick Cereal* (Mixsell)—Preparation of the Cereal Feeding—My stock formula

is made up as follows: 1 per cent. skimmed milk is used, as the liquid basis of the mixture. It has been my experience, and this has been noted by many others, that babies with any degree of malnutrition, whether long-continued or temporary, will not tolerate or assimilate fat well. To conform this in my series a number of stool examinations were done on cases fed on fairly high fat before they were put on thick cereal. Fat indigestion was noted in almost every case. Other factors which influence me in using skimmed milk are its comparatively high sugar, proteid and salts content, in comparison to whole milk, and its actual food value of twelve to thirteen calories per ounce. If the cereal is cooked in water these needed calories, salts, sugar and proteid are lost.

The cereal used by preference is *Farina*. This is advocated on account of its colloidal (glutinous) qualities and its extreme tenaciousness. Although farina is less soluble and has less protected colloids than rice, I use it on account of this tenaciousness and because of the fact that to get the same resulting thick mixture almost twice as much rice flour is needed. The proportion of the mixture is as follows: One level tablespoon of farina is used to five to six ounces of skimmed milk. In very young infants or prematures the skimmed milk may be diluted with water, half and half. We have had a number of such cases at the Nursery and Child's Hospital. Our statistics show, however, less gain on partially thick mixtures than there is on the thick feeding. Cane sugar and dextrimaltose are then added, using at first two level tablespoons of dextrimaltose and one level tablespoon of cane sugar to thirty ounces of the mixture. All this is cooked together for thirty to sixty minutes, using either a single or a double-boiler, until the resultant mixture is so thick and tenacious that it *will just barely fall off an inverted spoon*. Thorough cooking is an absolute requisite. If cooking is not thorough, owing to the encouragement of a saccharolytic flora, the baby may get up a diarrhea, and accordingly will not gain.

Administration of the Thick Cereal.—

The activity of the amylolytic and diastatic ferments in the digestive tract of the new-born infant has long been recognized. From birth onward there is a rapid increase in an infant's capacity to digest starch, until by the eighth or ninth month life this capacity is fully developed. Because of this fact starch has not been added

*Read before the medical section of the Rutgers Club, New Brunswick, N. J., December 8, 1922.

to the infant's dietary until the fourth or the fifth month, and then in the form of barley water or a similar diluent. It is my contention, however, that infants, even as young as a week, tolerate starch, and tolerate it well. This view is borne out by both Graves and Chapin in different series reported by them.

When first put on a thick feeding there is usually some difficulty in getting the baby to take the spoon feeding. To overcome this difficulty the cane sugar, being much sweeter than the dextrimaltose, should be increased for the time being and the baby will then generally take it. Incidentally, there may be gagging, and in some cases vomiting, until the infant is accustomed to such a radical change in its diet. The method of administration is simple. I use either the handle of a small spoon, or a small wooden tongue blade. The cereal is placed on the back of the infant's tongue, thus facilitating swallowing. At first this may prove tedious for the nurse, and may take her from one-half to one hour to feed the baby. Gradually, however, the baby takes it with avidity. If a thinner mixture is to be given, a nipple with a large hole may be used, either with a bottle or alone, and then using a tongue-blade to force it through the nipple. The amount to be given, of course varies. I generally start in with seventy to eighty calories per pound of baby weight, divided into the requisite number of feedings for the child's age. Either three or four-hour intervals may be employed, and in accordance with the calories, from two to four ounces are given at a time. One may find that a larger allowance may be demanded and tolerated to maintain a satisfactory gain. I have run the calories as high as 100 per pound, with no bad effects, but, of course, for no great length of time. When the child is well-accustomed to the mixture and has started to gain, from one to three ounces of a green vegetable puree is added directly to the cereal. This may be used as early as the third month. String beans, spinach, carrots, celery and young turnips are the vegetables of choice. These supply not only a few extra calories, but also salts, and the anti-neuritic or water soluble B vitamin. The combination of these factors acts as an added incentive to increased growth, and to nutritional improvement and turgor. It is important to give orange or prune juice to these infants, from the very inception of the thick cereal feedings to counteract any possible tendency to scurvy, and inci-

dentally to aid in bowel elimination. In this connection I have found dextrimaltose No. 3 of aid in counteracting constipation, where it occurs.

In regard to the length of time that one can keep a child on thick cereal there is no fixed rule. In one of my cases it was continued for eight months, with good success. Naturally other articles of diet were added, from time to time, the vegetables in particular being emphasized. In most of the cases it seemed best to make a change back to a milk formula within a month's time, dry milk being used in the majority of cases, as a bridge between the cereal and whole milk, the rationale of its use being its low fat and high sugar content. Naturally this change must be done slowly and carefully, the thick cereal being continued twice a day, as the child's regular cereal. When the infant is weaned from the thick feeding one will usually find that they have gotten into the habit of gaining, and the change back to milk seldom affects them badly.

Water Administration.—To supply the water deficiency of this diet in these babies there should be given boiled water in amounts up to four ounces three or four times a day. In vomiting babies this may be given with or without a stomach tube, and then preferably at night, as they seem to retain it better then. However, in a number of my cases, and Graves has had the same experience, no water whatsoever was given, even during the hot part of the summer. These babies did not seem to get particularly thirsty; there was no edema or evidence of water retention, and normal urine was passed in normal quantities.

Indications for Its Use.—I have used this feeding in the following types of cases:

- 1, Malnutrition (Marasmus); 2, Pylorospasm (mild and severe); 3, Pylorus stenosis; 4, Breast fed colic cases (as an A. C. feeding); 5, Persistent vomiting (neuropathic); 6, Idiosyncrasy for breast milk and for cow's milk; 7, Liquid food intolerance; 8, Acute gastritis, with vomiting; 9, Eczema and allied skin conditions; 10, Acute ileocolitis, with vomiting; 11, Prematurity, with defective assimilation; 12, Acute infectious fevers.

Illustrative Case.—C. H., age ten weeks; male; born March 6, second child; full term; normal baby; birth weight, 7.8. Family history negative. Was nursed four weeks and then weaned. A formula of dryco, dextrimaltose and water was ordered. This was gradually increased

until, when seen by me at ten weeks, he was being fed dryco, 4 tablespoons; boiled water, 4 ounces; dextrimaltose, 2 teaspoons. He was given seven feedings every three hours, and had been getting enough calories per pound, the estimated calories being over sixty-five. Examination revealed a physically normal child, but marantic in appearance, weighing 8-12. There had never been any evidence of indigestion, and the failure to gain was the chief source of worry to the parents.

This child was put on a thick cereal feeding of skimmed milk, 26 ounces; farina, 4 level tablespoons, and granulated sugar, 2 level tablespoons. This was boiled thirty minutes and three tablespoons were given at 6, 10, 2, 6, 10. This was gradually increased to 2 per cent.; milk, 27 ounces; farina, 5 tablespoons; 2 tablespoons of granulated sugar; $1\frac{1}{2}$ tablespoons of dextrimaltose, and late 1 tablespoon of spinach or string beans. An immediate change for the better followed. The weights for the ten weeks following were: May 22, 8-12; May 29, 9-9; June 5, 10-1; June 12, 10-7; June 19, 10-12; June 26, 11-3 $\frac{1}{2}$ (spinach added); July 3, 11-12; July 10, 12-4; July 17, 12-12; July 24, 13-5; July 31, 13-14.

In ten weeks this child gained eighty-two ounces, or an average of $8\frac{1}{4}$ ounces a week. In appearance he changed from a sallow, undernourished marantic child to a fat, rosy, happy one. Naturally all of our cases do not respond to treatment as readily as this one did.

2. *Czerny-Kleinschmidt Butter Flour Mixture*.—For a great many years it has been a recognized fact that a relationship in the diet closer to the proportions seen in breast milk would be a very desirable thing. Czerny and Kleinschmidt, accordingly devised this method of feeding and produced a food which permitted the employment of a high fat percentage in combination with a high carbohydrate percentage, but with the protein reduced to approximately the amount present in human milk. The relationship of the fat and the carbohydrate in this mixture is a fixed one, and as soon as this relationship is altered the results are not so good. They believe that the favorable results are to be ascribed in part to the driving off of the volatile fatty acids from the milk fat; in part the admixture of an amount of flour equalling that of the fat; in part to the chemical alteration of the flour produced by the browning, which occurs during the preparation, and in part to the low percentage of

protein present, the last being especially important in weakly marantic infants.

The proportions of the mixture consist of 7 grams of butter, 7 grams of flour, 5 grams of sugar and 100 grams of water, all of which is mixed with varying amounts of milk, according to the little patient's age. In the actual process of preparation five teaspoons of butter are placed in a pan and heated over a gentle fire until foaming takes place and until any odor of volatile, fatty acids present disappear. This usually requires three to five minutes; five teaspoons of fine wheat flour are then added and the mixture boiled for four or five minutes over a gentle fire, with constant stirring, until the mass becomes thin and brown; ten ounces of water and three and three-quarter teaspoons of cane sugar are added. These are all boiled for one minute, rubbed through a fine sieve and then mixed with the desired amount of previously boiled, cooled milk, and the whole is kept cold in an icebox until needed for use. For children under six pounds in weight, one-third milk is added to the butter flour mixture. For those over six pounds, two-fifths milk and three-fifths butter flour mixture is used. Not more than three fluid ounces to the pound should be given, on account of its high caloric value. The number of feedings given is that of a normal child, the average calories being seventy to ninety per pound.

This formula may be used in: 1, Marasmus (malnutrition); 2, Prematurity; 3, Difficult feeding cases; 4, Eczema; 5, Vomiting, pylorospasm; 6, pyloric stenosis. Contraindication: 1, Excessive vomiting; 2, Diarrhea, with fever; 3, Very severe malnutrition.

In spite of the high fat content of the butter flour mixture, vomiting seldom occurs. On the other hand, vomiting will frequently stop after its administration. Those that do vomit usually respond badly to the mixture and are babies who have previously vomited on other mixtures. Another point in the feeding is that these babies begin to gain immediately.

Illustrative Case.—J. B., age six months, admitted to the Nursery and Child's Hospital weighing ten pounds; negative physical examination. Diagnosis: Marantic infant; past feeding history was that of: 1, Breast feeding, 1 month; 2, Whole milk modifications, 2 months; 3, Various patent foods, including Mellin's food, Eskay's food and Nestle's up to time of admission. This child was put on three-fifths butter-

meal mixture and a two-fifths whole milk and four and one-half ounces were given in six feedings. The improvement was quite remarkable in its steadiness, the infant gaining an average of seven ounces a week for four weeks, when he was discharged and watched in the clinic, and then gradually he was changed over to a proper cow's milk modification.

3. *Whole Lactic Acid Milk—Karo Syrup (Marriott)*.—It has long been a matter of common experience that infants and young children suffering from gastro-intestinal disturbance are able to take larger amounts (and stronger) of artificially soured milk (with lactic acid bacilli) than they can of sweet milk modifications. Buttermilk and more recently protein milk have both been used for this purpose in the past, but both of them are low in caloric value and, therefore, are not adapted for feeding marantic infants for any length of time, especially those under two months of age and six pounds in weight. To overcome this difficulty there has been devised the method, which we know as the whole lactic acid milk-Karo syrup mixture. This combines the properties of a lactic acid milk with the high caloric value of the glucose. The form of commercial glucose used in Karo (corn) syrup, which is a mixture of dextrine (55 per cent.), maltose (30 per cent.) and glucose (15 per cent.). In other words, a polycarbohydrate syrup, which ordinarily is so well tolerated.

The method of preparation is as follows: Whole milk is sterilized by boiling, cooled to room temperature, inoculated with a culture of Bulgarian bacillus and incubated over night. The thick syrup being difficult to handle is diluted one-half with water, 100 cc. of this containing 50 gms. of carbohydrate. This is measured in a graduate and added to the whole lactic acid milk and kept in a refrigerator until used. The mixture should not be agitated sufficiently to separate the fat as butter. As such mixtures are very thick a nipple, with a large hole, must be used in feeding.

In beginning this feeding it is advisable to begin with a mixture of equal parts of whole lactic acid milk and buttermilk (fat free lactic acid milk). The proportion is then slowly increased until whole lactic acid milk is fed; 3 per cent. of sugar is added at first. If no diarrhea occurs the sugar percentage is gradually increased, depending on the infant's tolerance and the amount of food necessary to cause a gain in weight. As high as 15 per cent. has been

given. The number of ounces of the milk mixture given at a feeding should be the same approximately as if breast milk is fed. Four-hour intervals seem preferable. We have found this method of feeding of great value in acute and chronic gastro-intestinal upsets. It is quite surprising how much they will gain on it once they get started. In this respect it is similar to the thick cereal feeding, although totally different in composition.

4. *Eiweiss Milch (Finkelstein) Protein Milk*.—Although this special feeding is a pre-war product it is sufficiently new to be included here. Protein milk can be easily prepared in the home as follows: To one quart of warm whole milk a junket tablet is added and is gently stirred. It is then allowed to stand at some temperature for twenty to thirty minutes, or until firmly coagulated, and then poured upon two layers of gauze or cheesecloth and suspended for an hour to drain off the whey. The curd is then washed twice, with cold, boiled water, after which the dry curd is rubbed through a fine sieve, with a vegetable washer, gradually adding one pint of buttermilk. Enough boiled water is then added to make the quart. In this way we obtain a mixture moderately low in fat (2.5 per cent.); low in sugar (1.5 per cent.); high in protein (3.5 per cent.). The advantages of protein milk depend on its low sugars, its relatively high fat and insoluble salts, especially calcium, whose soups favor the production of formed stools; the high protein, whose putrefactive action acts in opposition to the fermentative action of a sugar diarrhea, and to some degree to the lactic acid bacilli contained in the buttermilk. It can be used in both acute and chronic digestive disturbances, with carbohydrate intolerance, especially those associated with diarrhea. It is *not* an infant food for prolonged use, but merely a therapeutic agent. However, we do sometimes combine it with carbohydrate, especially a non-fermentable poly-carbohydrate, such as dextrimaltose, on the same principle as the whole lactic acid milk-Karo feeding. Sugar is added previous to getting back to a normal diet.

Where one has no facilities for getting or making protein milk there is a tinned preparation containing eight ounces of concentrated protein milk put out by the Beebe Laboratories, of St. Paul, Minn., which is prepared in accordance with Finkelstein's formula. In using it, it is necessary to thoroughly shake the tin and empty its con-

tents through a strainer or sieve into a clean quart measure. With a spoon gently force the protein material through the sieve. Sugar, if prescribed, should be dissolved in a little hot water and then sufficient hot water should be added to make a quart.

Illustrative Case.—H. S., age, four months; weight twelve pounds, was brought to the hospital with fever, foul, green, watery stools, fourteen to twenty a day, markedly prostrated and with marked water loss. Diagnosis made of acute intestinal intoxication, from improper feeding of Mellin's food. (This was in the summertime). The child was immediately given normal saline by hypodermoclysis and intraperitoneally; 10 per cent. glucose solution being given in the longitudinal sinus in addition to supplying his water loss. His feeding was ordered as follows: Five ounces of protein milk were given every four hours for five feedings. Water was given by mouth in between feedings. Within five days he had become constipated and was perfectly well and happy. This is a true case of fermentative diarrhea cured by a simple measure and without drugs. Incidentally, we feel that drugs, and especially cathartics, are not needed in this condition, as the mucous membrane of the intestinal canal is already in a *weakened condition*.

5. *Casec, Larosan (Calium Caseinate).*—These two preparations are so similar in all their essentials that I have grouped them together. They are really powdered protein, or Eiweiss Milch, and are used in a similar way, especially in the fermentative sugar diarrheas. Casec is our usual choice at the Nursery and Child's Hospital, on account of its ease of preparation. It is prepared as follows: Two-thirds of an ounce of casec is mixed with a little cold water to form a paste; when thoroughly mixed, a pint of water is added, and, stirring constantly, it is slowly brought to a boil. In the preparation of protein milk there is added to this mixture one point of either whole milk, skimmed milk or buttermilk; our usual choice being skimmed milk. If the casec solution is added to buttermilk one must be careful to cool it, otherwise the hot solution will cause the buttermilk to curdle. It is obvious that in a country practice, or where one cannot get or hasn't the time to make protein milk, this preparation is of extreme value. Larosan is prepared in almost the same way as casec, and is equally as valuable as casec.

A good powdered protein milk is put out by the Merrell-Soule Company, of Syracuse, N. Y. It is entirely ethical, as there are no directions on the box, and one must prescribe it in accordance with the child's condition.

6. *Synthetic Milk Adapted (Serstenberger).*—This preparation, as its name indicates, is an adapted synthetic milk, so made up as to resemble human breast milk, with special reference to the fat. It is universally known that young infants cannot take as high a percentage of cow's milk fat in their food as they can of breast milk fat. It also will be readily recognized that whenever the fat in artificial food is increased, the protein is also automatically increased to nearly the same total amount, while in human milk there is always, after the second week of life, a decided difference in the percentage content of the fat and the protein, the difference being: Fat, 4-5 per cent.; protein, 1.5 to 2 per cent. Another marked difference in the fat is the larger percentage of volatile, fatty acids present in cow's milk fat, 16 per cent., as compared to 10 per cent. of human milk fat. These volatile, fatty acids play an important part in the production of not only the chronic, but also the acute nutritional disturbances of children.

These volatile, fatty acids have already been referred to in the buttermeal preparation, in regard to the importance of eliminating them. The chemical formulae of the mixture is the following: Fat, 3.5 per cent.; sugar, 7.5 per cent.; protein, 1.2 per cent., and ash, 0.2 per cent. It is not necessary for me to describe its preparation, as it can be bought at almost any drug store under the name of S. M. A. It is interesting, however, to know that the fats used are tallow oil, cocoanut oil, cocoa butter, cod liver oil and tallow. These combine three factors: 1, Saponification; 2, The presence of an adequate amount of the fat soluble growth factor (vitamine fat soluble B), and 3, Cod liver oil, as a prophylactic against rickets. In using it one will find it only necessary to add water to the mixture in amounts sufficient to supply the child's required calories. The type case indicated for its use is the infant who will not gain, or will only gain on breast milk, or infants who have been on many previous formulae, with bad results. Our best results are obtained in the premature infant and those infants markedly underweight.

Illustrative Case.—D. M., breast-fed for

two weeks. Then artificially fed on Melin's food and condensed milk for one week. Admitted to dispensary at the age of three weeks, weighing six pounds, twelve ounces; ill with vomiting and diarrhea. She was put on S. M. A. and kept on this for one year. Orange juice, farina, green vegetables were added from time to time. After three weeks of S. M. A. she had gained up to eight pounds, four ounces, or a gain of twenty-four ounces, and at a year she weighed twenty-four pounds. (Case reported by Dr. Gerstenberger).

7. *Dry Milk Feedings*.—There are three popular kinds of dry milk in the market, namely: Dryso, Mammala and the Merrell-Soule Dry Milk. They are similar enough to classify them together. As my experience in private and in hospital work has been largely limited to Dryco I will confine myself to that preparation. Its use is very simple; as a matter of fact, it is the lazy man's delight—as all that is necessary in its preparation is to dissolve it in hot, boiled water and add a little sugar. All dried milks are partially skimmed to prevent fat decomposition, the percentages of Dryco being: Fat, 12; sugar, 44; protein, 34; salts, 7, and moisture, 3. Our method of giving Dryco is to estimate the number of calories needed by the child's weight and age, and giving a trifle less than is needed in terms of Dryco and sugar. Incidentally, dextrimaltose usually is the sugar of choice. For example: A two-months'-old baby, weighing ten pounds, would require about forty-five calories per pound, or 450 calories, so that approximately ories. Each tablespoon of Dryco contains twenty-eight tablespoons of Dryco would be needed. This may be divided into six or seven feeds, making each feeding consist of four to four and one-half level tablespoons at a feeding. The amount of water needed is never less than one ounce more than there are tablespoons. In other words, four tablespoons of Dryco take five ounces of water or more. In addition, one-half to one teaspoon of dextrimaltose is generally added, for its caloric value and on account of its tendency to prevent a protein diarrhea, due to the high protein content of the dried milk.

Dryco is of value in the following conditions: 1, Prematurity (where breast milk is unobtainable); 2, Marasmus; 3, Gastro-intestinal upsets, with vomiting; 4, In hot weather (will not spoil or get sour); 5, For long trips; 6, Normal feeding cases; 7, Difficult feeding cases.

CONCLUSIONS.

1. In this brief paper we describe some of the newer methods of handling an old problem.

2. None of these methods are panaceas. The individual child must be handled, as a separate study.

3. In the last analysis, the doctor who can get a mother to nurse, or can capably feed cow's milk modification, will be able to capably feed 95 per cent. of all his feeding cases with success.

161 East 64th Street.

Note.—This paper is merely a compilation of different articles on the various sub-heads mentioned; in some instances the articles are quoted verbatim. The excerpt on thick cereal is from a paper read before the Pennsylvania Medical Society at the 1922 meeting in Scranton.

IMPORTANCE OF SLEEP IN INFANCY AND EARLY CHILDHOOD

By Dr. Joseph H. Marcus, M. D.

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The attitude assumed by the child during sleep is well worthy of notice. A healthy infant generally lies on his side, or rather with his body semi-prone or prone, and with his head turned face downwards on the pillow. The limbs are often fully flexed, so that the knees have a tendency to touch the abdomen, and the hands are close up to the chin. As Henoch pointed out, this posture may be regarded as reminiscent of intra-uterine life. The attitude is apt to be altered in disease, and, therefore, the more or less characteristic attitude presented in sleep, in any case is a reassuring sign. The eyes should be closed in healthy sleep and the mouth should also be closed. If the mouth is kept open habitually during sleep this suggests the probable presence of enlarged tonsils or adenoid growths.

The amount of sleep required by children at different ages varies to a great extent with the individual. The newborn infant sleeps almost constantly, waking only for its feedings. During the first three months of life twenty to twenty-two hours out of the twenty-four. During the second three months it sleeps somewhat less, ranging in

duration from sixteen to eighteen hours. In the second half of the first year, the infant should sleep at night from 6 p. m. to 6 a. m., without interruption, except for feeding or nursing, and should have two two-hour naps during the day, one between 9 and 12 in the morning, and one between 12 and 3 in the afternoon, although it is not well to have the baby sleep after 3 o'clock in the afternoon. The periods devoted to exercise, amusement and play should be between 6 and 9 in the morning, and between 3 and 6 in the afternoon. The twelve-hour night rest should be continued until the child is six or seven years of age, and as they grow older some children develop the habit of waking up earlier in the morning, which earlier rising is no indication for making the retiring hour any later than accustomed. This habit may often be corrected by making certain that the nursery is kept darkened in the morning. At one year of age, one hour in the morning and two hours in the afternoon suffice. From the eighteenth month to the second year, the morning nap is usually dispensed with. Afternoon rest for at least two and one-half hours should be continued until the sixth year, and longer if the child is inclined to be delicate. Even if the child shows no inclination to sleep, he should be made to rest in bed and relax for the above-mentioned periods of time. It is very important that the infant be trained from birth in proper habits of sleep, and if the infant is started properly with suitable feedings given at definite periods, followed by the proper intervals of sleep, but little trouble will be experienced. The baby should never be rocked to sleep, and preferably should not be rocked to sleep in its mother's or nurse's arms, but should be accustomed to be placed in the crib alone, in a quiet and darkened room and go to sleep of its own accord. All artificial devices for inducing sleep should strictly be avoided and habits instituted, such as permitting sleep to occur while on the breast, the use of a nipple, rocking, only are the fore-runners of pernicious habits. When sleep is broken or disturbed it implies bad habits, the presence of noise, light hunger, unsuitable food, indigestion, wet napkins, pain, or a positive illness of some kind. A proper amount of sleep is essential to nutrition, and in secondary

mal-nutrition and anemia, the value of added rest in the form of sleep or relaxation by bodily rest is of inestimable value. The great importance of sleep to children with an acute illness is not to be forgotten, and the patient must not be lightly awakened even for the purpose of feeding.

DIAGNOSIS AND TREATMENT OF CARDIAC IRREGULARITIES.*

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The paper consisted essentially of a discussion of the clinical features of each type of irregularity. In each case the differentiation by the ordinary clinical methods was emphasized. At the same time the underlying mechanism responsible for the irregularity was illustrated by lantern slides, showing typical electrocardiograms of each condition. The irregularities which occur, as sporadic disturbances of a dominant rhythm, were first considered; ventricular and auricular premature contractions. These were distinguished from the irregularities, due to partial block. When the stethoscope is applied to the apex while a beat is missed at the wrist, an extra beat at the apex is audible in the case of premature contractions, whereas complete silence at the apex occurs when the missed beat is due to block.

Paroxysmal tachycardia, although not strictly an irregularity, was also considered; its relation in mechanism to auricular premature contractions was demonstrated and its recognition clinically by the sharp onset and offset of attacks indicated. Auricular fibrillation was illustrated by a series of slides, showing digitalis and quinidine effects. A point in the clinical diagnosis of fibrillation, important especially in slow fibrillators, and called "the blood pressure test," by the speaker, was the following: When the blood pressure cuff has been inflated so as to obstruct all pulsations the observer will hear with the stethoscope placed beneath the cuff only an occasional beat come through at first, when the cuff is deflated. After the pressure in the cuff is lowered still further an increased number of beats

*Read at the meeting of the Bayonne Medical Society, held November 20, 1922.

will come through; the essential point is that a **very wide range** of pressure exists, over which beats come through in increasing numbers. In the normal heart (sinus rhythm) all the beats will come through at a fixed point corresponding to systolic pressure. The presence of a pulse deficit also assists in verifying the diagnosis and in estimating the effects of treatment.

In closing, the speaker wished to emphasize the fact that the use of instrumental methods should have as its first object the training of our senses, so that the clinical diagnosis of these conditions might be more easily made, with recourse to instrumental means in the more obscure conditions.

THE ELIMINATION OF SALVARSAN IN URINE*

By **Leo Koppel, M. D., and Armin V. St. George, M. D.,**

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The excretion of arsenic from the body, when administered in the form of one of the salvarsan preparations, is a subject which has interested the attention of many European investigators. Amongst these, the papers of Usulli¹, Ullman², and Abelin³ deserve mention. The former observer found that, after the intravenous injection of salvarsan, the excretion of arsenic in the urine began within two or three hours and continued from ten to twelve days thereafter. Karl Ullman found the excretion of arsenic to be greatest on the first day subsequent to the intravenous administration of the drug and that the elimination decreased rapidly thereafter. Abelin devised a technic for the rapid clinical estimation of the elimination of the salvarsan in the urine.

Believing the subject of value, both from a medico-legal, as well as clinical (therapeutic) viewpoint, we commenced a study of it. However, shortly after we began our investigations, a series of articles appeared in the American Literature. Among these, Underhill & Davis's⁴ very complete study, is of great value. These workers made complete quantitative estimations on the urine and faeces of two patients, em-

ploying the Sanger & Black modification of the Gutzeit reaction. They demonstrated that arsenic appears in the urine within a few hours after intravenous injection of arsphenamine and that the maximum excretion occurs on the first or second day after injection. They also showed that arsenic appears more slowly in the faeces, but is eliminated in them for a longer period of time. An apparent saturation point of the tissues is also stated to occur. Weiss & Raiziss⁵, using a modification of the Green iodometric micro-titration method, demonstrated that the largest amount of arsenic is eliminated in the urine within the first three days, but that only a relatively small portion is eliminated through the urine, the larger amount passes through in the faeces.

Fordyce, Rosen and Meyers⁶, in a comprehensive study of the biology of salvarsan on some of body fluids, only a part of which has been published, have detailed some interesting and instructive problems. For example, a point in question bearing on the elimination of unaltered salvarsan from the body, led them to the conclusion that there is an active, as well as inactive, portion of the drug, and that the elimination of salvarsan in Wassermann-fast cases may be the result of a large amount of unaltered salvarsan being eliminated. In the writer's opinion, based on our observations, this possibly might be stated in another way, viz: There is a used, as well as unused, portion in the salvarsan molecule, and the elimination of unaltered salvarsan depends entirely upon the amount which the body uses. Beeson and Albrecht⁷ used the clinical test, devised by Abelin, but modified it slightly, which is applicable to urine. They concluded that the test is extremely sensitive and of real value. Gerhard Muller⁸ employed the Abelin reaction, with success, and stated that salvarsan (not arsenic) could be detected in the urine on an average of thirty-seven hours after injection. He also made the interesting experimental observation that sub-lethal doses of strychnine, given to previously salvarsanized animals, resulted in early death, with symptoms suggestive of strychnine poisoning. From his observation it is obvious that strychnine should not be given to patients under salvarsan treatment.

After considerable examination and preliminary experiments, we concluded that the Abelin reaction was of sufficient clinical value to be employed, particularly as it appeared that salvarsan elimination and not

*Read at the clinical conference of the staff of the Jersey City Hospital, January 12, 1923.

arsenic (either as metallic arsenic or one of its oxides) was of greatest import. Unfortunately, satisfactory quantitative determinations were not obtainable, though it is possible that, with further experimentation, a satisfactory colorimetric method may be established. Using the Abelin test, we carried out our method in the following way: The specimen of urine was collected immediately after the administration of salvarsan; thereafter the patient's urine was collected every six hours. He was given a specimen bottle and told to pass every drop of urine in it. This was continued for at least a week, and in instances where the patient received a weekly injection, the specimens of urine were continued to the laboratory. Each specimen was examined by the Abelin method, using the ring test, as suggested by Beeson and Albrecht.

Records were kept on sixty-three patients, and it was found that in patients who had received their first injection of salvarsan, that salvarsan appeared in the urine within six hours after administration, and the test was no longer positive at the end of thirty hours, as an average. In those who had received two or more injections, a similar result was found. In those having received five injections, the average point at which the test became negative was at the end of thirty-six hours. Hence, in long, continued treatment, elimination of salvarsan is prolonged. This result would seem to indicate that there is an apparent saturation of the tissues with the drug, and, perhaps, delayed utilization of it.

The test, when applied to the feces, was negative. Experiments carried out in the test tube, using the various dilutions of salvarsan, showed the Abelin reaction to be positive in the proportion of 1 to 100,000. Control tests made on normal individuals, as well as cases of pneumonia, non-syphilitics, cardiacs, gastro-intestinal cases and patients receiving certain drugs, salicylates, etc., were negative.

CONCLUSIONS.

1. The Abelin test is of real clinical value. It can be rapidly applied and can be used as an index to the rate at which salvarsan should be administered.

2. Sensitiveness of the test is very great. It has been shown in our preliminary experimental work, as well as by others, that the test is not given by other medicaments of the benzine series. Controls run on pneumonias, non-syphilitics, cardiacs and gastro-intestinal cases do not furnish a positive reaction; elimination may be prolonged

in patients who are given more than five doses. Failure of elimination of the drug should place one on his guard as to the possibility of salvarsan poisoning.

We desire to thank Dr. John Nevin, medical director of the hospital, for his great interest in permitting patients to be kept in the hospital and assigning attendants to collect the specimens of urine, and providing chemicals and apparatus.

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Clinical Reports.

Case of Congenital Dislocation of the Hip.

By Lancing Y. Lippincott, M. D.,
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Lucy B., twelve years and ten months old, came to me in August with the usual symptom of dislocation of the hip. The left leg was two inches shorter than the right, with all the shortening at the hip, with the well-known one-sided waddle of dislocation. She complained of no pain and had been able to run and jump all her life without discomfort, except for the limp. The parents stated that they had noticed the limp for about six years. No attention had ever been paid to it. No information was obtainable as to its presence or absence in early childhood. Probably the condition was congenital. The child's mother was dead, and her step-mother could give no more definite information than given above.

Radiograph examination showed the head of the femur two inches above the acetabulum, with considerable atrophy of the head. The acetabulum was indistinct in outline and apparently filled in.

Operation at Middlesex Hospital, September 14, Dr. A. L. Smith was good enough to help me, and Dr. Nafey put Lucy to sleep.

We followed the typical Lorenz method of bloodless reduction. The thigh was flexed to a right angle and then abducted, using considerable force and kneading and pounding, and stretching the abductor muscles. Also the leg was flexed, with the knee extended, again using as much force as we dared. The head of the femur easily slipped from its false position with every manipulation. Tracton also was used.

After an hour's hard work we suspended operations and took her to the x-ray room. The picture showed that an upward dislocation had been converted into a backward dislocation, which didn't help any, so we went at it again. But the picture showed us what we had to do. Then we requisitioned Mary (the hospital skeleton) and laid that out on a stretcher in a corresponding position. With the radiograph and Mary helping to visualize what was needed, the leg was fixed on the body, abducted and rotated outward and then brought downward in the plane of the body, and to our great gratification slipped into place, with a distinctly palpable and audible click. We measured carefully and found the distances to the knee corresponded.

At this particular happy moment I leaned on the table, which gave way, and I went down to the floor, and the hip was again out of joint. However, having once succeeded, the second time was easier, and we soon had it back.

A plaster of Paris spica was applied, with the leg abducted at nearly a right angle to the body. Lucy has had quite some pain since the operation, but is doing nicely now and has quite recovered from the operation.

Whether the acetabulum will hollow out and become a useful socket or not we scarcely venture to prophesy. The only really unusual feature of the case was the age of the child. I believe it is considered that a child nearly thirteen years old is not a good subject for this operation. We felt that Lucy was entitled to a try for it, and since we succeeded in reducing the dislocation we are encouraged to hope that next year she may be able to walk normally.

The accompanying radiographs show the hip before, during and after operation. Time, 2½ hours.

Remarkable Operation for Brain Tumor

This operation was performed by Dr. K. Winfield Ney, assisted by Dr. Emil Altman, at the Beth Israel Hospital, New York city, on H. A. Brown, of Newark, N. J., who had been suffering for a year from intense headaches, accompanied by gradually increasing delirium and partial coma. His life had been despaired of. His grave had been purchased, and his family reconciled to the fact that he could not live. It was decided that he had a brain tumor and that his only chance was an operation. Finally he was taken to Beth Israel Hospital for an operation. Because of his weakened condition, it was decided that he could not stand a general anesthetic. He consented to an operation under local anesthesia. This took place February 27, the technique of the operation is described, as follows, by Dr. Frank: "After the necessary skin incision was made, a number of holes were bored into the skull. The holes were connected, and the bone and overlying structures were turned down. The dura, or covering of the brain, was incised. The tumor was visualized and the carefully incised. It was necessary to sacrifice the anterior portion of the frontal lobe of the brain, but this will not affect the mentality of the patient. After this the osteo plastic flap was turned back

and the scalp sutured. The tumor which was removed was four inches long and two inches wide and three-quarters of an inch thick. It was of the benign type and self-contained. Great care was exercised during this entire procedure. No unnecessary manipulation of any of the vital structures was performed." The patient was able to talk during the operation. He has recovered so completely that he expects soon to resume business.

Diabetes Mellitus—Two Cases

Dr. Alexis F. Hartmann reported these cases at a meeting of the Washington University Medical Society, St. Louis, Mo., January 15, 1923:

The first case was a boy of four years, who has had diabetes for two years. On admission to the St. Louis Children's Hospital six weeks ago he weighed fifteen pounds, now weighs twenty. As might be judged, his emaciation was extreme on admission. And, moreover, at that time there was also considerable nutritional edema, which has disappeared. His carbohydrate tolerance was about 10 grams. At the present time his diet consists of protein 80 grams, carbohydrate 30 grams and fat 120-150 grams. He has four feedings a day. He is given fifteen rabbit units of insulin three times a day before feedings and shows no ketosis and only slight glycosuria at the height of digestion. He is gaining weight steadily on this diet, which furnishes him 150 to 200 calories per kilo of body weight.

The second case in a girl nine years old, who had diabetes for six months. Her tolerance is 12-15 grams. Her diet now is carbohydrate 25 grams, protein 100 grams, fat 160 grams. There are three meals a day and before each meal she is given five rabbit units of insulin. She is diabetic free and only occasionally has glycosuria. She weighs twenty kilos and is gaining.

(Experiments with animals have shown insulin to be very toxic, and in several human cases the margin between the therapeutic dose and the toxic dose may not be great, so that the use of insulin is not always free from danger. The experience, however, of careful men in several clinics leaves no doubt of the great clinical value of insulin in restoring the power to burn carbohydrate. Dr. Hartmann referred to the importance of watching very closely the blood and urine sugar, in order to prevent the effects of an overdose of insulin. He said it is best given before meals, so that its greatest effect comes at the height of digestion. Dr. W. H. Olmsted referred to glucose as the antidote for insulin poisoning by overdose, and said its use produced a rapid cure.—Editor).

Pregnancy Following the Menopause.

Dr. Murray L. Brandt, of New York City, reports the following case in the N. Y. Medical Journal and Medical Record of July 5, 1922:

Case.—Mrs. S. S., forty-six years of age, began to menstruate at thirteen, was always regular every twenty-eight days, married at eighteen years and since then had eleven preg-

nancies resulting in twelve children. The last labor occurred at thirty-nine years of age. Following this labor, the patient menstruated regularly for a year, the last period occurring in June, 1916.

In March, 1919, she applied for treatment for an increasing size of her abdomen, increasing weight and intra-abdominal movements. Examination showed a much enlarged pendulous abdomen, fundus of uterus above umbilicus, fetal parts not definitely distinguished and no fetal heart could be heard. A diagnosis of pregnancy was suggested and on examination a month later distinct fetal parts and fetal movements were found.

In May, 1919, the patient was delivered of a male child weighing nine pounds. Incidentally this child showed all the signs of achondroplasia. Ten months after the birth of the child the patient, after weaning the baby, began to menstruate and had three normal periods. The menses have not returned since then.

Comment.—Although the patient presented a large uterus, the diagnosis of pregnancy at the first examination was rather difficult because of the vague history of intra-abdominal movements since the cessation of menses three years before. A diagnosis of fibroid uterus had been made elsewhere and operation was urged.

The literature discloses only five other authentic cases of pregnancy occurring after menopause.

County Medical Societies' Reports

ATLANTIC COUNTY.

Royal E. Durham, M. D., Reporter

The regular meeting of the Atlantic County Medical Society was held at the Hotel Chalfonte, Atlantic City, on March 9, 1923.

Dr. Lewellys F. Barker of Baltimore, Md., spoke on "The Present Status of Epidemic Encephalitis;" Dr. Lewis A. Connor of New York City spoke on "Modern Views Concerning Digitalis and Its Administration," and Dr. John A. Kolmer of Philadelphia spoke on "Immunity in Syphilis with Special Reference to the Significance of the Wassermann Reaction."

Dr. Barker said that lethargic encephalitis was on the increase in this country and was becoming epidemic. The disease may simulate any psychosis and the early symptoms are indefinite and a diagnosis can often only be made when late evidences of the disease are manifested. The majority of cases show an early diplopia without strabismus, a loss of accommodation without paralysis of the pupil and any ocular muscle may be paralysed. Digestive disturbances are not uncommon and there is often a tendency for the patient to sleep during the day and to remain awake during the night. In later stages of extreme cases there is often a development of Parkinsonian symptoms. In this type of case the prognosis is very bad. Milder cases, however, have a fairly good prognosis. The etiology of the disease is not known but is supposed to be a filterable virus. The treatment is essentially rest over a long period of time and symptomatic treatment. Rosenow's serum has

been thought to have beneficial effects and is worth trying.

Dr. Connor said that strophanthis was one hundred times more powerful than digitalis and that the action of the two were identical. Its use was, however, unsatisfactory because of the difficulty of its absorption and occasionally a too rapid absorption produced grave toxic symptoms. Digitalis acts by slowing the heart beat and by increasing the force of the ventricular contraction. Its diuretic action is simply an indirect result of increasing the circulation in the kidney. Digitalis raises blood pressure clinically only in large doses and not in ordinary doses. It lowers blood pressure in hypertension, of a compensatory nature to maintain circulation in the vital centres, by reestablishing the circulation. Its emetic effects is not a local effect upon the stomach but is a toxic effect and is due to a reflex from the heart to the vomiting centre. Any preparation of digitalis that is not inert will cause vomiting if given to the limit. Digitalis slows the heart by stimulating the vagus centre in the medulla which regulates the stimuli for contractions from the pace maker node, and also by impairing impulses thru the Bundle of Hiss. The latter slows the ventricles only.

Clinically digitalis is used in cases of normal rhythm and cases of auricular fibrillation. In latter cases are seen the brilliant results from digitalis. In normal rhythm cases we get very little slowing of the heart or none at all. In auricular fibrillation there is much slowing by blocking many a feeble stimuli at the A. V. Bundle of Hiss. Auricular fibrillation is the commonest of all cardiac irregularities and occurs chiefly in mitral stenosis, Grave's disease and senile myocarditis. Digitalis is absorbed rapidly. A single dose of 3 or 4 drams shows effect in 3 or 4 hours which is full and pronounced in 8 to 10 hours. The full effect holds from 10 to 14 days. Of the preparations the infusion is the only unstable one. All other preparations remain potent for months and even years. The older the tincture the more potent it may be. Of the proprietary preparations digipuratum and digitan and digolen and digifoline are trustworthy. However, the best preparations are the tincture and powdered drugs. As to dosage, give digitalis until full effect is obtained and then maintain the effect with smaller doses. Give 2 minims per pound of body weight as for instance a man of 150 pounds would require 300 minims of 5 drams to produce a full effect. This should be given in the first two or three days. Begin with large doses and then taper them. The average patient tolerates 20 or 25 minims daily after being digitalized.

Dr. Kolmer said that the incidence of lues according to the Wassermann reaction shows 10 per cent. of the population to be leucic. Altho lower animals are peculiarly immune to syphilis, humans are not and the only immune humans are those who already have syphilis. We may have very small or no lesion at the point of entry of infection, especially of the neuro-trophic type of spirochaete. Hence the history should not carry too much weight. Children of a leucic mother may have an in-

herited immunity but they also inherit the spirochaetes and have positive Wassermanns later on. In these cases the degree of immunity only holds the spirochaetes in a latent condition. A patient with lues can rarely be re-infected although he does not have an immunity to spirochaetes in his body. A luetic patient cannot cure himself. Spontaneously but may have stages of latency due to the life cycle of the spirochaete and not to immunity. The higher the type of organism the lesser our natural immunity. Hence we are less immune to protozoa than to bacteriae. Even after a patient is cured of lues there is no immunity.

Leprosy and Malaria do not give a plus Wassermann unless there is also syphilis present. However, a negative Wassermann may be falsely negative in lues with such few organisms or organisms so latent that there is not enough reagin in the blood to produce a plus reaction. Hence if we have clinically syphilis and a negative reaction, we must not be influenced by the negative reaction for this is a real biological error in the test. Again the blood may be negative and the spinal fluid positive, probably because the latter is used in larger quantities in the test. Persistent plus Wassermanns always have living spirochaetes in the body. The spirochaetes are rapidly disseminated from a chancre and the first evidence of resistance to the spirochaete is found in the surrounding tissue to the chancre. Hence excision of the chancre should not be done. In primary and secondary lues the spirochaetes are in the blood and not in the tissues or parenchyma as in the latter stages. Hence give large doses of arsenic in the primary and secondary stages. In the Wassermann test we detect an antibody in the blood called reagin. This protects against reinfection but not against the progression of patient's own disease. The Wassermann is not a specific biologically for lues but reagin is not produced by other diseases. Hence the Wassermann test is trustworthy. Frambesia, a tropical disease, is the only other disease producing a plus Wassermann reaction. The Wassermann is the best guide we have to treatment of syphilis and Dr. Kolmer advises the quantitative test in order to better show improvement by the different quantities of serum used.

ESSEX COUNTY.

Dr. E. W. Murray, Reporter.

A meeting of the Essex County Medical Society was held to consider assembly bills Nos. 225 and 412. It was decided to oppose bill 225 and each member of the society was asked to get in communication with his Senator and Assemblymen. The president of the New Jersey Chiroprody Society addressed the meeting on bill 412, and asked the society's aid to help prevent chiropractors not qualified from practicing the art. The question allowing physicians to prescribe alcoholic liquors for medicinal purposes was referred to a special committee to report in October. Dr. Emerson, of Boston, addressed the society on the subject of nutrition.

GLOUCESTER COUNTY

Henry B. Diverty, M. D., Reporter.

The Gloucester County Medical Society held their regular meeting yesterday afternoon at Hotel Paul, with a very good attendance, which included delegates from the county medical societies of Camden, Salem and Cumberland counties.

The committee on speakers was fortunate in being able to have two Philadelphia physicians, Dr. Robert M. Lukens and Dr. William F. Moore, both of whom are associated with that world renowned physician, Dr. Chevalier Jackson, of Jefferson Medical College. Dr. Jackson, in his bronchoscopic work, is well-known for the success which he has achieved in the removal of foreign substances from the lungs. The doctor makes his own instruments, which he uses for the removal of the substances from the lungs, and in cases where open safety-pins have been swallowed he has been able to close the pin, while in the lung, and then remove it. In past years the removal of such substances was only accomplished by surgical operation, 80 per cent. of the patients dying, while under the method now in use the death rate is very low.

The speakers of the afternoon spoke upon the subject "Bronchoscopic Treatment of Asthma, Bronchiectasis and Pulmonary Abscesses." The addresses were illustrated with lantern slides and charts. A display was also made of the instruments which are used in their work.

Following the addresses, the association held a banquet.

The association accepted the invitation of Dr. Madeline A. Hallowell, of Atlantic City, who conducts a sanitarium for feeble-minded persons, to hold their May meeting in the parlors of the sanitarium.

HUDSON COUNTY

Wm. Freile, M. D., F. A. C. S., Reporter

The Hudson County Medical Society met at the Jersey City Hospital on March 6th, 1923, and was called to order at 9 P. M., Dr. Lucius F. Donohue, president, in the chair.

Report of Committees: The Welfare Committee reported that Senate bills 143 and 144 were defeated, due to division of opinion of the profession. They have called forth considerable discussion and acted as educational factors, even though defeated. The Naturopathic bill probably will not come out of Committee.

Assembly Bill 225, proposes to allow about a hundred Chiropractors to practice without examination, even though they had no license when the bill went in. This was defeated 35 to 14. However, bill came up again and passed Assembly because an appropriation bill came up to fight illegal practitioners. Probably Dr. MacAlister approved bill without notifying the Welfare Committee. If this is so, we should do all in our power to prevent the election of Dr. MacAlister at Convention.

A motion was made that the Secretary communicate with Senator Simpson, stating that this bill should not be allowed to pass, because of no educational requirements, and this was carried.

Entertainment Committee reported that the

banquet was successful, with a balance of \$9 on hand.

Dr. Kuhlman of the Membership Committee reported no new members proposed.

Dr. Margaret N. Sullivan spoke about Dr. Faison's death, and suggested that a \$50,000 memorial fund be raised, the income of which to be used as a scholarship fund, and this was discussed by Drs. McLaughlin, Nelson, Kelley and Bortone. It was further moved that this discussion be held over until the next meeting, and included in call for next meeting, which was seconded and carried.

Reports of clinical cases: Dr. Rosenkranz spoke of the good effects of Cod Liver Oil in furuncles, etc.

The paper of the evening, read by Dr. Warren Coleman, entitled "Flora of the Intestines," was discussed by Drs. Rosenkranz, Von Deesten, Bortone and Jaffin, and was closed by Dr. Coleman. The Journal hopes, in an early issue, to publish this paper.

MIDDLESEX COUNTY

J. Francis Weber, M. D., Reporter.

The quarterly meeting of the Middlesex County Medical Society was held March 21, 1923, in the Nurses' Home Auditorium of the Perth Amboy Hospital, President Naulty in the chair. The president appointed the following committees:

Professional Welfare, Drs. A. Clark Hunt, F. C. Henry, Jr., F. L. Brown and J. L. Lund; legislative, Drs. C. F. Merrill, C. I. Silk, A. Gruessner; Medical ethics, Drs. J. F. Anderson, L. Y. Lippincott, J. S. Hay; business and program, Drs. J. F. Fagan, E. F. Klein, F. C. Johnson.

On motion, Drs. Haight, Howley and Fithian were appointed a committee to consider the advisability of sending the magazine, "Hygeia," to various school boards in the county, with power to act.

Dr. D. C. English spoke of the campaign to largely increase the capacity and efficiency of the Middlesex General Hospital at New Brunswick, and of the splendid work that is being done by all of our county hospitals. The society passed a resolution congratulating the Middlesex General Hospital on its past work and best wishes for the present campaign's success.

President Naulty presented a brief address concerning the society's past and future work. He referred to the recent death of Dr. Clarence M. Slack, the oldest member of the society, and the society expressed its sorrow in parting with this able and highly-esteemed member, and its sympathy with his bereaved family. On motion of Dr. Haight, the president and secretary were appointed a committee to congratulate the Perth Amboy Hospital authorities on the erection of the beautiful auditorium addition to the Nurses' Home.

On motion, it was voted to have a "Ladies' Day" in connection with the society's quarterly meetings, possibly on the evening of the annual meeting. It was referred to the business and program committee. On motion of Dr. Haight the welfare committee was directed to consider the work of dispensaries and clinics in providing free treatment and report their conclusions at the next meeting of the society.

MORRIS COUNTY.

Marcus A. Curry, M. D., Reporter.

The quarterly meeting of the Morris County Medical Society was held on the afternoon of March 13 at the Elks' Club in Dover. President George H. Lathrope presided over a fairly good assemblage of members.

Four amendments to the bylaws of the society were adopted:

1. Providing for the selection in alphabetical order of delegates and alternates, excepting permanent delegates, to the annual meeting of the State Society.
2. Providing for a nominating committee, consisting of seven members, four of whom shall be the president, vice-president, secretary and treasurer, who shall serve ex-officio; the other three to be elected, or if not elected, to be appointed by the president.
3. Providing for the election of three members of the nominating committee at the March meeting each year, or appointment by the president at that time. This committee to report its ticket at the June meeting. This procedure is designed merely to expedite nominations for office and in nowise to prevent any member from making such other nominations as he may desire at the annual meeting. (Drs. Flagg, Costello and Curry were elected members of the committee).
4. Providing for honorary membership, to enjoy the privilege of the clinical meetings of the society, but without the privilege of voting, holding office or joining in the business transactions, and carrying no privileges or connection with the State Society.

The meeting was of dual major interest in that the members were privileged to hear well-delivered discourses by Dr. John C. McCoy, of Paterson, in a "Presentation of Hirschsprung's Disease," and Dr. Allen O. Whipple, chief surgeon, Presbyterian Hospital, New York city, on "Pre-Operative and Post-Operative Treatment of Lesions of the Biliary Tract." In introducing his subject, Dr. McCoy said that since coming out of the army he had seen recently the third case of Hirschsprung's disease, being the second case he had operated on in two or three years, and in going over the literature on the subject for the past few years, he found it was not so unusual as one might consider; that he realized that the disease must be of interest to medical men, because of the third case coming to the Paterson General Hospital recently; that his only excuse for presenting this particular case was that it happened to come from this immediate vicinity, being a case referred by Dr. Kice, who had known the patient since childhood.

The subject of this report was a boy, seventeen years of age, admitted to the Paterson General Hospital on January 23, 1923. The boy was referred for relief of: 1, Abdominal distension; 2, Chronic constipation; 3, Abdominal pains. Since birth, according to the mother, the boy's abdomen has been enlarged and he has always been constipated. When a baby he would go a week without a bowel movement, unless relieved by enema, when the discharges would be most offensive; the distension of the abdomen, when a baby, seemed to be mostly upon the left side; after a long period of constipation he would at times have a diarrhea, lasting a day or two,

having a number of liquid evacuations; these movements would be particularly offensive; the diarrhea was relieved by enemata. The condition became more pronounced, and the boy was taken to a private hospital in Newark, N. J., when he was nine years of age. Here his abdomen was opened, and the mother stated that the surgeon said: "The boy had tubercular peritonitis, with paralysis of the large bowel, which was very much distended." Electrical treatment was used, and the appendix was removed at that time. Following the operation there was no relief of symptoms. The distension and constipation have been present since birth, and the boy has always required an enema to relieve his distension and empty the bowels, as even large amounts of cathartics failed to help. He would go three weeks, at times, without a movement. During the last five years the boy stated he would "fill up" every two or three weeks, the abdomen gradually becoming larger and rather tender to pressure over the entire left side. The distension could be somewhat relieved by massaging the abdomen, after which he frequently passed a large amount of flatus. After emptying the bowels the patient noticed, during the first week, that there was gradual distension but no pain; during the second week he would feel uncomfortable, particularly after eating. His diet was regular and abundant. At the end of the second week he felt filled up, had abdominal pain, but no desire to move the bowels. He had learned to administer his own enemata, and at the end of each two weeks would take four injections of water, each one consisting of four quarts, to empty his bowels. The first two or three passages were hard and the last one soft and very offensive. The boy had not lost flesh until within the last three months, during which time he had been unable to attend to his work as usual, owing to the attacks of abdominal pain becoming more frequent. He never vomited, appetite always good, and up to three months ago he was able to work every day and was not fatigued by exercise. At no time was there evidence of colitis nor has the patient observed blood in the movements.

Operation, February 8, 1923; temp., 99; resp., 20; pulse, 86; gas oxygen anaesthesia.

Gross Findings: The abdominal wall very thin. Immediately upon opening the abdomen there presented the huge descending colon. Its surface was white, glossy and hard to the touch. The peritoneum of the abdominal cavity was normal. No free fluid in the peritoneal cavity or evidence of pre-existing or present peritonitis. The incision was extended upward, through the median line, and below extended through the old supra pubic-scar. The wall of the distended colon was tremendously hypertrophied and hard. There were several areas of pigmentation, particularly in the region of the sigmoid. The greatest amount of distension was in the left iliac region. The colon having the appearance of a cone, with its small end at the splenic flexure. The transverse colon was about four times its normal size; but just below the hepatic flexure the ascending colon was about twice its normal size; as the cecum was ap-

proached the ascending colon appeared normal, as was also the cecum. The appendix had been removed. The meso colon of the descending and transverse colon was very thick, vessels tremendously engorged, and lymph nodes enlarged; some of them to the size of a hickory nut. The meso colon of the first portion of the ascending colon, and cecum was less thick, and the enlarged glands not so marked. The small intestine was apparently perfectly normal, as was also its meso colon. The stomach, spleen, pancreas and kidney normal to palpation. Liver normal. Gall bladder was distended, but readily emptied. The colon was delivered, clamped at its distal end, just below the sigmoid, and midway between the cecum and hepatic flexure, with thermic clamp. The distal and proximal ends were then closed and the charred surface inverted.

The descending and transverse colon was delivered; meso colon ligated, with very little bleeding, linen thread being used for ligatures. A lateral anastomosis was then made between the ascending colon and the portion of the sigmoid, where the resection had occurred. It is to be noted that the most marked area of distension of the colon terminated abruptly in the sigmoid, which was apparently normal. A rectal tube was passed through the rectum to beyond the anastomosis. The abdominal wall was closed in the usual manner, with a flank drain leading to the site of the anastomosis. Time of the operation was one hour and ten minutes. The patient left the table in excellent condition.

Forty-eight hours after the operation there was a rather profuse, bloody discharge from the drain, with distinctly fecal odor. The patient's condition became grave, and he showed an evidence of general peritonitis, from which he died on the third day after the operation. Autopsy showed a considerable hematoma at the site of the anastomosis, behind the posterior parietal peritoneum, and there was leakage from a small opening in the posterior part of the anastomosis. Owing to the thickness of the meso colon it may be assumed that there was a retracted vessel, which was not included in the ligatures. Had it not been for the slight opening in the anastomosis, and bleeding, it is fair to assume on the basis of the patient's general condition following the operation, that he might have recovered.

Description of specimen exhibited by Dr. McCoy: Entire length, from rectum to hepatic flexure, 27 inches; circumference of the sigmoid and ascending colon to within six inches of the splenic flexure, 21 inches; circumference of the splenic flexure, 11 inches; circumference of the hepatic flexure, 9½ inches. The resected colon contained fourteen and one-half pounds of pasty, dark, fecal matter of very offensive odor. The mucous membrane was smooth, numerous small areas of superficial necroses and dotted throughout with hemorrhagic spots, varying in size from pin-head to that of a dime. No valvular folds were demonstrable and no areas of constriction. The specimen held, distended to its full capacity, twenty-one quarts of water. The walls varied in thickness, at some points being extremely thick

and hard, while in other places the wall was attenuated and when the fresh specimen was filled with water these latter areas bulged out beyond the main wall.

Dr. McCoy said that the fact that so many theories as to the cause have been advanced, is evidence of the uncertainty of our knowledge; that the most striking feature of this case, other than the dilatation, was the thickness of the meso colon, with the engorged vessels, suggesting hypernutrition, resulting in giantism; that the tremendous hypertrophy of the muscularis would seem to disprove that the condition is due to neuro-muscular defect; that sigmoid dilatation may be either congenital or acquired, and the idiopathic type is known as Hirschsprung's disease, in which the sigmoid has excessive length and mobility.

In introducing Dr. Whipple, President Lathrope said that Dr. Whipple holds the chair of surgery at Columbia University, and as you know is a full job now and is what is called a full-time job, and Dr. Whipple is the first incumbent since that new arrangement was made, and it also involves the chief surgeonship at the Presbyterian Hospital; that one of the things Dr. Whipple has been interested in for a number of years past is gall bladder surgery and is well qualified to speak on the subject he has chosen. He very ably and with much pains of detail covered his subject of "Pre-Operative and Post-Operative Treatment of Lesions of the Biliary Tract," stating that during the past decade there has been a progressive improvement in results following operative treatment of disease of the biliary tract and pancreas; that there is, however, a tendency to overestimate the operative technique, as the determining factor in the successful results and low mortality. Dr. Whipple covered the importance of understanding the "living" pathology. Dr. Whipple based his observations upon a study of 212 unselected, consecutive cases of surgical disease of the biliary tract and the pancreas operated upon by him, since the inauguration by him of an analysis chart, the histories being analysed while the patients were in the hospital, and of the 189 cases leaving the hospital, 187 have been personally seen or heard from in the Follow-Up Clinic. Dr. Whipple's paper presented much illuminating detail and was painstakingly read. (Paper has been promised for publication in the Journal.)

Dr. Julia Mutchler addressed the meeting on the work of the State Welfare Committee, explaining the status of the pending bills having a bearing upon the profession and suggesting the importance of the physician keeping in familiar touch with pending legislation concerning the profession; also citing certain organizations and individuals favorable and opposed to certain bills.

Dr. Curry, being called upon, explained the purposes of Assembly No. 317, which was designed to carry out a definite institutional construction program throughout the State, which is much needed, owing to the overcrowded conditions and the inadequate provision now existing for the care of the State's wards.

The speakers of the day were the recipients of a hearty expression of approval of their

helpful discourses, which were taken up for discussion by Drs. Flagge, Lathrope, Wigg and Curry.

An unusually inviting and appetizing luncheon was enjoyed at the Elks' Club, and verified the reputation of the club for the excellence of its cuisine.

Dr. Lathrope announced that through the courtesy of the managers of the Shongum Sanitarium (Morris County Tuberculosis Sanatorium) the next meeting would be held at that institution probably the third or fourth Tuesday in May, to meet the convenience of the hosts. An eminent speaker on the tuberculosis problem will address the meeting, which will be open to lay friends of the profession and those interested in tubercular work.

PASSAIC COUNTY.

Leon E. DeYoe, M. D., Secretary.

The March meeting of the Passaic County Medical Society was held at Odd Fellows' Hall on Thursday, March 8, at 8:45 p. m. President J. A. Maclay presided.

The address of the evening was by Bernard Stafford, assistant prosecutor of the pleas, of Passaic County, on the subject of "Abortion, from the Legal Point of View." Mr. Stafford enumerated the various legal steps necessary to bring a case to trial, and spoke of the rules of evidence governing these cases. He spoke of the great difficulty in securing the conviction, due to the secrecy which surrounds the commitment of the crime. The speaker then read the statute of New Jersey, dealing with this crime.

Dr. J. C. McCoy reported a case of herschsprincicys disease and presented the specimen of colon, which he had removed. The speaker then discussed this condition, and reviewed the literature of the subject.

Dr. J. S. Van Winkle, of Paterson, was elected to membership. Drs. D. E. Warren and L. H. Joyce, of Passaic, and Dr. Carlo Mozzorella, of Paterson, were reinstated to membership.

SALEM COUNTY.

William H. James, M. D., Reporter.

The regular meeting of the Salem County Medical Society was held at the Memorial Hospital, Salem, on February 14, 1923, at 2 p. m.

The society listened to a very interesting lecture by Dr. A. H. Super, of Allentown, Pa., connected with the Pennsylvania State Hospital for the Insane. His subject was "Premonitory Insanity." Dr. James Hunter, Jr., president of the New Jersey State Medical Society, was with us, and gave, among other things, a very fine talk on "Medical Defense Insurance."

As the meetings are held every two months the interest seems to be increasing, and the attendance is much better than when they were held only three times a year. The president, Dr. C. W. Thomas, has been able, thus far, to secure a very good speaker, and we hope the good work will continue. Dr. Davies, of Elmer, was elected a member at this meeting.

Those present were Drs. Sherron, Green, Davis, Hummel, Ewen, Church, Hilliard,

Smith and Hires, of Salem; Drs. Thomas and Husted, of Woodstown; Dr. Davies, of Elmer; Dr. Dyer, of Pennsgrove; Dr. Hunter, of Westville, and Dr. Super, of Allentown, Pa.

Local Medical Society Reports.

BAYONNE MEDICAL SOCIETY.

M. I. Marshak, M. D., Reporter.

The Bayonne Medical Society met at the Elks' Club on February 19, Dr. Williamson presiding.

Dr. Sexsmith reported a case of extreme diabetes mellitas, who gained twelve pounds on the insulin treatment, and who is now on general diet. Dr. Williamson reported a case of diabetes in a child of ten years, with 10 per cent. sugar. These reports were followed by a general discussion of the insulin treatment.

Dr. M. Shapiro then read the paper of the evening on the "Treatment of Syphilis and Its Relation to Public Health." He discussed the menace of syphilis to the clean-living public and to the economic welfare of the nation. He took up the various methods of treatment, both ancient and modern, and showed why some of the methods had to be abandoned. The value of mercury, arsenic and the salvarsans and their various preparations, when used separately or synergistically, were worked out in detail. The question of standardization was then taken up and the methods used were described. He laid stress on the use of the salvarsans, in conjunction with mercury, and especially on the fact that in making salvarsan solutions they should never be used until completely clear. "The important point being not the rate of solution, but the complete solubility." Quoting Cregor, he mentioned the following points: "1, The medical profession should take an uncompromising stand for the full and complete treatment of syphilis; 2, This can be done by the full co-operation with the lawfully constituted health organizations of the country; 3, Syphilis may be aborted if encountered before five weeks have elapsed from the contraction of the disease; 4, Syphilis may be cured by one year of treatment, providing it is encountered before it has found lodgment in the tissues of the host; 5, Syphilitics may be assured that they will remain free of symptoms, providing they fully co-operate in the treatment; 6, The Wassermann test should be employed as an aid and comfort, and not as a guide and control for action; 7, As full co-operation is impossible in the fact of ignorance of the disease and its potentialities, it is necessary that the patient be apprised fully and honestly of these things; 8, Steps should be taken to reclaim the neuro-syphilitics, possibly, through the insane institutions, until such time as the public enlightenment will relieve the present demand; 9, A spinal Wassermann test should be made in all cases before the patient is discharged. He concluded that the question of adequate and efficient treatment of syphilis is of the highest importance, from the public health point of view." The prevalence of the disease is so wide-spread that private clinics, as well as public health men, must combine

in their efforts, in order to eradicate this economic waste. The selection of only those products of the highest therapeutic efficiency should be made by the clinician, who wishes to obtain the most satisfactory results for the patient.

Discussion: Dr. Sexsmith stated that in the olden days symptoms were caused to disappear with mercury and massive doses of iodides. He asked about the effect of syphilis on the offspring. Dr. Weiss wanted to know if there was any preparation that could be used intramuscularly. Dr. Malloy: "If syphilis is cured by salvarsan and mercury, why forbid marriage." Dr. Williamson: "If mercury has no spiroceticidal effect, how do they effect the treatment."

Dr. Shapiro, in closing, said: "The health of the offspring of syphilitics depends, first, on the treatment, and, second, on Colle's law. In most cases the child is infected, though the symptoms may not appear until late in life. Intramuscular injections are only used in children, and then in minute doses. Mercury and the other drugs used in treating syphilis, increase the combative forces of the body. Syphilographers do not claim that they absolutely cure the disease; there are cases on record, since the use of salvarsan, where a second initial lesion was demonstrated. Time will tell whether the case is cured or not. Twenty years or more, without signs or symptoms, would be necessary to make sure."

BARNERT HOSPITAL CLINICAL SOCIETY

A. Shulman, M. D., Secretary.

The twenty-ninth regular meeting of the Barnert Hospital Clinical Society, Paterson, was held at the hospital on February 20, 1923.

Dr. W. M. Winters reported a case of auricular fibrillation. The patient, female, aged sixty-nine, was admitted, complaining of frequent urination, dyspnoea, oedema of legs and cyanosis. Physical examination disclosed rales at the bases of the lungs and a rapid, perpetually, irregular apex beat in the fifth space. There were no murmurs. There was palpable, but did not pulsate. The urine was a pulse deficit of forty. The liver edge showed a marked reaction for albumin, but was otherwise normal. There were mental disturbances also, chiefly delirium. The patient died after four days, in spite of digitalization.

Dr. Plaut discussed the etiology of auricular fibrillation, and suggested, as the probable origin, thrombosis or embolism in the small arteries leading to the sino-auricular node, or inflammatory destruction of the node.

Dr. Shulman discussed the use of quinidine in the treatment of the condition, as reported in the literature. He pointed out that it did not improve the functional capacity of the heart; that, when successful, it restored, for a longer or shorter time, the normal cardiac rhythm and that it was successful in approximately 50 per cent of cases.

Dr. LeVine reported a case of gastric ulcer, possibly malignant. The patient, a male, aged forty-four, complained for four years of epigastric and interscapular pain, eructations and vomiting, and had lost weight. The urine showed a small amount of albumin. The

Wassermann was negative. X-ray examination of the gastro-intestinal tract showed prolonged gastric retention, with a post-pyloric ulcer, possibly malignant. Operation showed a large mass, involving the gall-bladder, stomach and pancreas. During the operation a large perforation in the stomach wall, partially protected by adhesions, was found. Pylorotomy, with a polya-anastomosis, was performed. For two days the patient did well, but then developed marked aructions of gas, with rapid pulse and high temperature, and quickly died.

Dr. Plaut stated that the specimen showed a perforation of adjoining portions of the stomach wall, which had become adherent to each other, i. e., a perforation through all the coats of the stomach wall, from mucous membrane to mucous membrane. He had not completed the microscopic examination, and so was not able to say whether the malignancy was present or not. He was inclined to think not.

Dr. Spickers criticised the surgical procedure, in that too much had been attempted. He thought that gastro-enterectomy, with peritoneal drainage, would have been more advisable; later, the mass about the pylorus could have been excised.

Dr. Mendelsohn reported a case of cholelithiasis. The patient, a female, aged fifty-five, had had typhoid fever at forty-one, and had also had fourteen children. One week before admission she developed severe pain in the right hypochondrium, and vomited. There was no jaundice. Cholecystectomy and appendectomy were performed. Several gall-stones were found. There was profuse drainage for several weeks. The patient did not recover strength rapidly. After six weeks, the wound looked fairly clear, but had wide, gapping margins. These were sutured, leaving the lower angle open for drainage. After five or six days she developed abdominal pain without temperature. On the seventh day she had a chill, with epigastric pain. An abscess was found in the lower right abdominal wall. It was opened and drained. She died suddenly the same night. Autopsy was not permitted.

Dr. Spickers thought that the resuturing was inadvisable, and that the abscess in the abdominal wall, which was not in the zone of operative incision, might have originated in the stump of the appendix.

Following this meeting, a memorial meeting was held to pay homage and tribute to the late Professor Wilhelm Conrad Roentgen. Several members, who were familiar with his life and work, eulogized this great scientist. Great tribute was paid to his discovery of the Roentgenray. At the close of the meeting, the following resolution was passed:

"Whereas, Medical science and humanity have been so benefited by the epoch-making discovery of the late Professor Wilhelm Conrad Roentgen, and

"Whereas, The Almighty, in His infinite wisdom, has seen fit to remove from this life this learned scientist now; therefore,

"Be it resolved, That the Clinical Society of the Barnert Memorial Hospital does solemnly lament the loss the world suffers through his demise."

Rutgers Medical Club

At the annual meeting, held in March, the following officers were elected: President, Dr. F. L. Brown; vice-president, Dr. C. F. Merrill; secretary and treasurer, Dr. E. Irving Cronk.

NEW JERSEY SANATORIUM ASSOCIATION

B. S. Pollak, M. D., Secretary.

Regular meeting of the New Jersey Sanatorium Association was held at the Bonnie Burn Sanatorium, Scotch Plains, N. J., on Friday, January 19, 1923. In the absence of the president, Vice-President Newcomb presided.

Present: Drs. Buchanan, Dunham, Hulka, Gramsch, Morrow, Newcomb, Pattengill, Pollak, Runnells, Mr. McLeod and Dr. Murray, president board of managers, Union County Hospital.

The following members were elected: Drs. G. M. Buchanan, of Bonnie Burn; A. S. Gramsch, of Glen Gardner; J. Hulka, of Seacucus; A. Newpower, H. C. Pattengill and A. Stromwasser, of Glen Gardner.

Upon motion it was decided that all expenses appertaining to meetings would be defrayed by the institution where the meeting is held. Invitation from Dr. Morrow to hold the next meeting in May at the Bergen County Sanatorium was accepted.

Upon motion, the vice-president appointed a committee, consisting of Dr. Runnells, English and Pollak, to draft a form, wherein a general plan of accounting would be indicated, same to be submitted at the next meeting.

The secretary was instructed to write letter of condolence to widow of Dr. J. W. Fithian, a member of this society.

Luncheon was served from 1 to 2 p. m., after which the following papers were read: "Tuberculosis and the General Practitioner," by Dr. H. C. Pattengill; "Ten Years' Experience with Induced Pneumothorax," by the staff of the Bonnie Burn Sanatorium. A discussion followed in which all present took part.

A rising vote of thanks was given the board of managers, Dr. Runnells and staff.

New Jersey Society, Sons of the American Revolution.—The board of managers of this organization recently paid a tribute to the memory of Dr. Carl E. Sutphen, of Newark, who died at Rochester, Minn. He was referred to as "a faithful and skilled practitioner; veteran of the World War and a patriot of sterling worth."

Special Train for A. M. A. Meeting

The train for the special twenty-five-day tour, from New York city to the meeting of the American Medical Association in San Francisco, gotten up under the auspices of the Medical Society of the State of New York, is already filled. Another train will be arranged for if 125 more subscribers can be secured. In order to do this, however, it will be necessary for applications to be in not later than April 15.

All applications should be sent direct to J. S. McAndrew, tour agent, Lifsey Tours, Inc., 1472 Broadway, New York city.

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Any member failing to receive the paper will confer a favor by notifying the Publication Committee of the fact.

NOTE.—The transaction of business will be expedited, and prompt attention secured if,—

All papers, news items, reports for publication and any matters of medical or scientific interest, are sent direct to THE EDITOR, New Brunswick.

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THE 157TH ANNUAL MEETING

of the

Medical Society of New Jersey

Haddon Hall, Atlantic City, N. J.

June 21-23, 1923

A. M. A. ANNUAL MEETING

San Francisco, Cal., June 25-29.

CHANGE OF OFFICE

Having retired from the active practice of medicine, the Editor of the Journal has moved from his large office, 389 George street, to his residence, 65 Paterson street, New Brunswick. His hours will be: 9 to 11 a. m.; 6:30 to 7:30 p. m. His postoffice box will still be No. 83.

INDEX AND OFFICIAL LIST

We send with this issue of the Journal the Index of Volume XIX. Dr. Chandler will have ready the Official List of Officers, Committees, Permanent and Annual Delegates of the State Society to send to our members as a supplement to the May Journal. The delay in issuing the latter has been largely due to the failure of some county secretaries and treasurers to send

prompt and accurate reports of members (and their residences) who by prompt payment of dues were in good and regular standing. The reports as first sent in would, if published, have shown a loss of three or four hundred members, instead of a gain, as should be reported.

ACADEMY OF MEDICINE

The anniversary and dedicatory meeting of the Academy of Medicine of Northern New Jersey, held in the new auditorium of the Academy on the evening of March 21, was an occasion of far more than ordinary interest. Doctors and their wives, professional and business men and women filled the spacious and beautiful auditorium. The addresses by President De Schweinitz, of the A. M. A., and President Hunter, of the State Medical Society, and the anniversary discourse by Dr. John M. T. Finney, professor of surgery, Johns Hopkins, Baltimore, Md., entitled "Vicissitudes of a Doctor's Life," were exceptionally fine and elicited long and continued applause. We are glad to announce that these practical, historic and literary speeches have been promised by their authors to the Editor for insertion in the Journal, and they will probably appear next month.

"DOCTOR OF THE OLD SCHOOL"

The Editor has read with much interest the editorial in the Penn. Med. Journal on "Cyrus Lee Stevens—Doctor of the Old School." It was our pleasure to know Dr. Stevens, and we endorse all the editorial says of his life and service. We quote the following concluding part: "His efforts were ever toward an upward and better trend in medical practice. In life a Christian, in practice one who had sincere sympathy with his patients, and for the progress of the profession a tireless ardor which is hardly found today among medical men, his influence in the professional life of the State will be keenly missed. His work in the various offices which he held in organized medicine of the State also stands out preeminently as a milestone for the younger members of the profession. . . . One could write a long and exhaustive history of Dr. Stevens' life and yet not bring out any greater thought than the one which was always uppermost in his mind—organized medicine first for the benefit of the profession and of the public, and self last. May his example be emulated by the younger doctors of the new school, and of

all schools, who are endeavoring to practice the healing art within the confines of our great country!"

We are sorry to hear, as the Journal goes to press, of the serious illness of Dr. Ralph H. Hunt, of East Orange. He underwent a severe operation for disease of the stomach recently at the Orange Memorial Hospital. As president of the Essex County Mosquito Extermination Commission and holding other important positions, he is too valuable a man to be laid aside.

A WORD TO CONSULTANTS

We take the liberty of inserting the following communications from Dr. Beverley Robinson, of New York, to the editors of the New York Medical Journal and Medical Record, which appeared in the January 3 issue of that journal. They are on very important matters affecting our profession, which need careful consideration.—Editor.

"For many years I have thought what a model consultant the late Dr. Austin Flint, Sr., was. He would say with his genial, considerate manner: 'Doctor, tell me about your case.' After he heard your story in a room where you and he were alone, he would go into the patient's room with you. He would question and examine the patient, as much as he thought necessary or desirable, and would then, with a kindly, helpful word, retire to the adjoining room with you. There he would go over the case with you and say frankly, if he differed with you, as to the diagnosis or treatment. He would finally say: 'Doctor, subject to your approval, I would suggest that you try later, or now, the use of such a drug or mixture.' After leaving the room, one of the family of the patient would ask Dr. Flint what he thought about the patient, or what treatment he advised. With a smile he would answer, very pleasantly: 'Dr. Robinson is the attending physician. He will tell you and do everything required.' With that he would bow and leave the house, with a good day.

"Have I known other consultants to act in a similar, commendable manner? I have not. Usually they talk with one or other member of the family and say what they think or feel. Their words are frequently misinterpreted and hence cause trouble in lessening faith in the practitioner.

"As a rule, and Dr. Flint knew it, the practitioner knows his patient and family far better than the consultant can know

them. Hence, his advice is in reality more valuable. Occasionally the consultant's advice, or his diagnosis, is important and valuable. But this is not invariably true. Far from it. Therefore, the consultant should conduct himself in a fitting manner; namely, with due regard to amenities and to professional ethics, in the best sense. *'Verbum sat sapienti.'*"

PROFESSIONAL SECRECY

"Personally, I am of opinion that all knowledge obtained by the family physician in his professional relations with his patients should be kept inviolate in all cases, when to reveal it in court and to the public in this manner is most reprehensible and should not be permitted by judges, except where criminality affecting the people's welfare is directly affected. Therefore, I am absolutely opposed to physicians stating in court, as to illicit relations between the sexes, as to the existence of venereal or malignant disease, in the case of the patient, of abortion, caused by ignorant or foolish doing. There are also other cases in which the doctor should be absolved from making a statement, or even answering a direct question of the prosecuting lawyer. In cases where criminality is involved, then if the judge decides that the doctor must answer clearly and sufficiently, his moral allegiance to his patient is covered and he is not bound by any sense of professional correct doing, if he responds frankly and completely, so far as he knows."

IT IS TIME TO ANALYZE THE MOTIVES OF THE LEADERS IN OUR PROFESSION.

The doctors who make up the rank and file of the medical profession should bear in mind one fact, and that is that not one of the various schemes to socialize medicine has developed in the minds of lay individuals. They are proposed and supported by erstwhile leaders in the medical profession. The public is not demanding any such schemes as "pay clinics" as inaugurated by Cornell University, or "community clinics" advocated by Hugh Cabot of the University of Michigan, or the fifty-seven varieties of free clinics for the well-to-do proposed by public health officers. The people in the United States, even the poorest, receive better medical and surgical attention than is given the people of any other country in the world.

It is time to analyze the motives of the leaders in our profession when they propose radical innovations in the way of care for suffering humanity. Usually there will be found a "nigger in the wood pile" in the form of a desire for personal preferment or profit. However, "the worm is beginning to turn," and henceforth the uplifters in our profession will have to watch their steps!—Indiana State Medical Journal.

FIGURES NEVER LIE—BUT FIGURERS DO.

Those practitioners of the healing art who maintain that all pathologic conditions, from cancer to chilblains and from soft corners to hardening of the liver, are due to subluxated vertebrae impinging on spinal nerves are republishing their annual batch of "statistics" one the chiropractic treatment of influenza. The standard advertisement runs, in part, as follows:

The following Statistics of the 1918 "Flu" Epidemic are Respectfully Submitted:

One of Every 16 Patients Died Under Medical Treatments.

One of Every 127 Patients Died Under Osteopathic Treatments.

One of Every 513 Patients Died Under Christian Science Treatments.

One of Every 886 Patients Died Under Chiropractic Adjustments.

These figures, of course, are evolved from the inner consciousness of those gentlemen that furnish verbal ammunition for chiropractic advertising campaigns. But, even assuming them to be correct, just what do they prove? They prove that many more people die when under the care of a physician than die when under the care of an osteopath, a Christian science practitioner or a chiropractor. The medical profession is perfectly willing to admit this; it is equally willing to admit that the vast majority of those who die, die in bed. Neither of these somewhat self-evident propositions, however, argues that scientific medicine is more dangerous than chiropractic, "Christian science" or osteopathy, or that a bed is a dangerous place. They do prove that most people who are sick enough to be in danger of death are usually in bed and under the care of a physician. Any one who is familiar with the facts may admit that comparatively few people die while di-

rectly under "chiropractic adjustment" or any other of the fad "treatments." There are two outstanding reasons for this. The first is that the man who relies, for example, on chiropractic for the relief of some passing indisposition precipitately deserts this cult when he realizes that he is dangerously ill. Then he calls in a physician; should he die, he dies under "orthodox medical treatment." The second reason is that, should a patient die under "chiropractic adjustment," the law would require an inquest, as in very few states in the Union are these gentry permitted to sign death certificates. It is notorious that when the "patient" of the chiropractor becomes dangerously ill, the chiropractor urges the family to call in a physician!—Jour. A. M. A., March 11, 1922.

WHERE PHYSICIANS ARE NEEDED

The shortage of physicians in some rural communities has become so acute that they are being advertised for. Young physicians seem invariably to turn to the cities nowadays. When the old family doctor dies there is too often none to take up his practice in the country community. By locating in the city the young physician feels he can keep in step with his profession, can progress and become a specialist commanding fees far above those of the doctor with an average general practice. He goes where his ambition has the best opportunity of becoming a realization.

It is a situation that ought to demand the attention of the medical profession and of the leading farm organizations. A survey conducted by the American Medical Association shows that 1,695 out of the 3,027 counties in the country have no hospitals and that about 300 additional counties have hospitals with a very limited accommodation. Good hospitals in small towns and farm centers should be sought by rural communities just as much as good schools and better marketing possibilities.—The Country Gentleman.

Pasteur.—Valery-Radot quotes Pasteur as saying on one occasion: "A man of science should think of what will be said of him in the following century, not of the insults or the praise of one day." In commemorating Pasteur's one-hundredth birthday this year, audiences throughout the world will know nothing of the insults,

but, in this "following century," will unite in one great wave of praise. He did become a teacher, as his father so ardently wished, not indeed in the college at Arbois, not only in the universities of Strasbourg, Lille, or at the Ecole Normale, but a teacher at whose feet the civilized world still sits in grateful appreciation.—*The Nation*.

Verona's Medical Head

The most hopeful feature about the appointment of Dr. Byron M. Harman as medical superintendent of the Essex Mountain Sanatorium, the county's institution at Verona for tuberculosis sufferers, is the manner in which the selection was made. Apparently, the last thing thought of was politics. The chief and only aim of the freeholders' committee, which made the choice, approved by the board seems to have been to select on merit and fitness. The choice fell upon a young man of considerable experience.

The position to which Dr. Harman has been selected is one of great responsibility. If its duties are properly fulfilled it is worth all of the salary of \$4,800 a year, with maintenance, which is attached to it. The institution ranks with the greatest among the sanatoria of its kind. Some mistakes have been committed in connection with its enlargement to its present size, and it is not yet accomplishing all the beneficent results which the people of the county are justified in looking for from a capital outlay for construction of more than \$2,000,000 and an annual budget appropriation which amounts this year to \$335,000. . . . The appointee seems already to have scored at the Trenton State Hospital and in previous institutional experience, as well as in war work and in his personal service on a large scale, rendered under great difficulties, in Near East Relief work. The committee has given evidence of having gone about the filling of this position carefully and with only the best of intention in mind.

(Newark Evening News Editorial.)

Trained Nursing as a Seasonal Occupation.

The hospital standardization committee of the Medical Society of New Jersey is on the right track in its movement to form a class of attendants to supplement the work of registered nurses in the care of the sick. Just now there is a serious shortage of registered and practical nurses, as there is every year at this time. Since the appearance of influenza and pneumonia as regular visitations of the late winter and early spring, the profession of registered nurse has entered the ranks of the seasonal occupations. As soon as warm weather comes the demand for their services will fall off. In the meantime, however, families with stricken members are besieging the registry offices with demands that can not be met. Heretofore, the practical nurse has filled the gap, but now they, too, are proving too few for the need. A woman with a year's training can very easily prove her value in

cases where attendance, rather than expert nursing, is called for.—Newark News.

HAVE YOU PAID YOUR DUES?

Hospitals; Sanatorium,

State Hospital, Morris Plains.—The new psychopathic buildings are completed, but, while they are said to provide 400 new beds, they do not relieve much congested conditions and will put some new problems on a too small medical staff. To care adequately for 3,000 patients the institution should have at least six more doctors and from 500 to 1,000 more beds.

Jersey City Hospital.—The hospital report for the month of January showed that 805 patients had been admitted during the month, and that with 307 patients remaining from the previous month, 1,112 cases were treated; 703 patients were discharged during the month; 204 cured; 402 improved; 2 unimproved; 30 transferred to other institutions, and 65 died; 409 patients per day was the average for the month. In the dispensary, 2,688 cases were treated; 1,036 of which were new cases, and 1,652 being revisits. There were 142 major operations; 117 minor operations, and 62 tonsil and adenoid operations.

Muhlenberg Hospital.—The board of governors of Muhlenberg Hospital, Plainfield, recently announced gifts to the hospital of \$2,000 from the estate of Charles Schipper, \$1,500 from the Hofheimer Foundation, in addition to \$20,000 from Congressman Ackerman. The board has been advised by Arthur Tuttle that it is his intention to carry out the wishes of his late brother, W. E. Tuttle Jr., former State banking and insurance commissioner, and give \$25,000 to the hospital from the latter's estate. At the present time there are 152 patients in the hospital, the largest at any one time in its history.

Salem County Memorial Hospital.—Dr. William H. James reports the following for the month of February: Admissions, 52; discharges, 59; births, 10; deaths, 5; ambulance calls, 18; accidents, 5; patients returned for dressing, 3; patients treated at clinic, 43; operations, 19; xrays, 13.

Overlook Hospital Training School.—Four nurses graduated from this school on March 1. Dr. Thomas P. Prout, of Summit, delivered the address.

Pine Rest Sanatorium.—A new, private sanatorium has been opened at Ridgewood, N. J., for the care of all, except tubercular, mental and drug addict cases.

Bonnie Burn Sanatorium

Superintendent J. E. Runnells, M. D., reports that on February 1 there were 253 patients in the sanatorium; 146 males and 107 females. During the month twenty-five pa-

tients have been admitted; ten males and fifteen females. Ten of these admissions went to the preventorium. Among these admissions there were six re-admissions.

The admissions are classified as follows: Pre-tubercular (preventorium), 10; incipient, 1; moderately advanced, 2; far advanced, 12. Present, February 24, 1923, 259. This number includes eighty-eight children in the preventorium, and sixty-five out of county patients.

Hospitals in Japan.—In many of the general hospitals outside Tokio, male and female patients occupy the same ward. The lack of privacy is intensified by the presence of visitors and the dearth of screens. As a rule, the number of visitors is unlimited and they may stay all day. In other words, they may practically live with the patient. The Charity in Tokio allows visitors but half a day twice a week. The Leprosarium never admits them. The wards seem crowded, not only because of visitors, but also because of the number of personal belongings, which each patient provides. The following is one of the thirty-three rules for patients in a prefectural hospital: "The things the patient may bring on admission to the hospital are as follows: Toilet paper, night gown, towels, washbasin, teacups, charcoal, charcoal scuttle, fire shovel, fire tongs, floor cloth, cushion, bedpan (if the patient is unable to leave his bed) and sleeping mat and bedding of attendant." Most hospitals furnish bedding, but do not supply garments, except to charity patients.—H. J. Howard and W. G. Lennox, Modern Hospital.

MEDICAL EXAMINING BOARD'S REPORT

| | Examined | Passed | Failed |
|------------------------|----------|--------|--------|
| Arkansas, November .. | 7 | 7 | 0 |
| Dis. Columbia, October | 9 | 9 | 0 |
| Florida, October | 41 | 31 | 10 |
| Kentucky, December ... | 8 | 7 | 1 |
| Michigan, June | 116 | 114 | 2 |
| Minnesota, October ... | 14 | 14 | 0 |
| Nebraska | 1 | 1 | 0 |
| New Jersey | 12 | 6 | 6 |
| No. Carolina, December | 1 | 1 | 0 |
| Porto Rico, October... | 10 | 9 | 1 |
| Texas, June | 66 | 66 | 0 |
| Utah, November | 4 | 4 | 0 |

We have received the following from Dr. Macalister, secretary of our State Board of Medical Examiners, reporting a victory won in the New Jersey Supreme Court.—Editor.
Dear Dr. English:

We are enclosing a copy of the Supreme Court decision in the case of George C. Lezenby. The evidence in this case showed that the defendant gave only electrical treatments; he used an electric vibrator, an electric sponge and violet rays, and the judge of the District Court of Camden dismissed the suit, holding that the State Board of Medical Examiners had failed to establish any proof that the defendant had violated the medical act.

The board carried the case to the Supreme Court, and, as you will note from the enclosed decision, won. We consider this an important decision, as it establishes the giving of electrical and violet ray treatments, as the

practice of medicine and surgery within the meaning of the medical act.—Alexander Macalister, secretary.

The State Board of Medical Examiners of New Jersey, }
Prosecutor. }
vs. } On Certiorari
George C. Lezenby, Sr., }
Defendant. }

Argued, November 8, 1922; decided, February, 20, 1923. Before Justices Kalish, Black and Katzenbach. For the prosecutor, Garfield Pancoast, Esq.; for the defendant, Grover C. Richmond and Thomas F. McCran, attorneys-general of New Jersey.

PER CURIAM.

The defendant was found not guilty of a violation of the State Medical act, P. L., 1919; p. 482; in the District Court of the City of Camden. The writ of certiorari was issued to review judgment of the District Court in that respect. Our reading of the testimony in the record leads us to the conclusion that the judgment of the District Court cannot be sustained. At the conclusions of the case each party moved the court for a direction of a verdict. That of the State was denied, and this action of the court is alleged as error. The question involved is whether or not the undisputed testimony does or does not show that the defendant violated the act. We think it is undisputed and uncontradicted that the acts of the defendant brought him within the provisions of the statute, that he was guilty of a violation of its provisions. It is admitted that several persons received from the defendant electrical treatments. The record shows he treated Sadie Britton, Nora G. Allison, Grace Haines, Ada C. Haines, Henrietta Myers.

The judgment of the District Court of the City of Camden is reversed.
Filed, February 20, 1923.

Enoch L. Johnson.

Deaths.

CASE.—In Montclair, N. J., March 3, 1923, Dr. Levi W. Case, aged seventy-three years. Dr. Case was born in Frenchtown, N. J., January 28, 1850; graduated from Lafayette College and the College of Physicians and Surgeons in 1880; he began practice in Chester and removed to Montclair in 1889, where he continued till taken ill two weeks ago. He was a member of the Associated Physicians of Montclair and Vicinity, the Orange Mountain Medical Society, Essex County Medical Society and the State Medical Society. He was connected for some years with Mountain-side Hospital and for many years was diagnostician at the Essex County Isolation Hospital, Soho. He was also diagnostician for the Montclair Board of Health and examining physician at the Immaculate Conception Parish School.

The Mountainside Hospital staff took the following action on his death:

Dr. Case was a loyal member of the Mountainside Hospital staff for many years, and we shall sorely miss him. He began on the

out-patient staff, served on the assistant staff, on the visiting staff and for the past ten years had been physician emeritus.

We shall always remember his kindness, his patience, his fund of humor, his good fellowship and his sound medical knowledge and good judgment. We have been honored to have such a scholar and a gentleman one of us. To the younger of his colleagues he was held up as an example of faithful devotion to duty. We and this community are losers in his going.

To his stricken family and friends we extend our deep sympathy.

Levi W. Halsey, M. D., president; Walter B. Mount, M. D., secretary.

CONOVER.—In Elizabeth, N. J., March 4, 1923, Dr. John H. P. Conover, aged fifty years. Dr. Conover was born in New York city; graduated from Rutgers College, New Brunswick, and from the College of Physicians and Surgeons, Columbia University, N. Y. He was city bacteriologist and on the staff of St. Elizabeth's and the General Hospital at Elizabeth.

The Union County Medical Society adopted the following resolution of regret:

"Dr. Conover graduated at the College of Physicians and Surgeons in New York in the class of 1899. He served his internship at the Post Graduate Hospital in New York and began the practice of his profession at Elizabeth, New Jersey, in the year 1902.

"By his energy, his skill and his devotion to the ideals and the precepts of his profession he soon attracted the attention of his fellow practitioners. He was successively a dispensary surgeon, assistant surgeon and finally pathologist at the Elizabeth General Hospital and the St. Elizabeth Hospital, city bacteriologist of the city of Elizabeth and surgeon to the Pennsylvania Railroad. The last four positions he held at the time of his death. He was for twenty years a member of this society and served as its president. This society desires to testify to Dr. Conover's worth as a man, to his high conceptions of the duties of a physician, and to his exceptional skill and attainments in his chosen work, and his exemplary life as a Christian gentleman.

"Dr. Conover's life is one worthy of emulation by all the members of our profession, and in his death we feel that this society and the profession at large have lost a highly skilled and respected member, and the State a high type of useful citizen."

DE MUND.—In Ridgewood, N. J., in February, 1923, Dr. Cornelius A. De Mund. He graduated from Cornell University Medical College in 1900.

FAISON.—In Jersey, February 24, Dr. William F. Faison, aged fifty-eight years. Dr. Faison received his degree in medicine from the University of Virginia. Coming to Jersey City thirty-two years ago, he became associated with the late Dr. John D. McGill, and the two men remained close friends until the latter's death, a few years ago. Dr. Faison's nature was so simple that this very simplicity made him beloved by all. He was

a man of great ability, but never appreciated that ability himself. He was a student of marked learning, and only a short time ago told the writer of this that he was in the habit of falling asleep about 8 o'clock at night, and after four or five hours' sleep, he would get up and read from about 1 until 5 a. m. He felt that these hours were the quietest, and in that way he kept abreast of the times, or in some ways, one might say, ahead of the times. His utter disregard for financial return on his work and his devotion to the poor is too well known to need any comment; in fact, words fail to convey any adequate description of this lovable and beloved man. In his early professional life, Dr. Faison visited several of the principal surgical centers in Europe, and on several occasions spent his vacation visiting the Mayo Clinic. As is well known, in the last five years, he took a very great interest in the study of cancer, and was the first man in Hudson County to use radium in fighting that disease. His extreme modesty about his accomplishments in the use of radium and his surgical dexterity was characteristic of the man. In the death of Dr. Faison, the entire community has suffered a great loss, but it is particularly within the ranks of the profession itself that he will be most missed.—Hudson County Medical Society.

NISHAWITZ.—At Hackensack, N. J., February 16, 1923, Dr. Louis Nishawitz, an intern at the Hackensack Hospital. He graduated from the Long Island College Hospital in 1922; he was killed, as his auto was struck by a train.

SUTPHEN.—In Newark, N. J., March 3, 1923, Dr. Carl E. Sutphen. Colonel David A. Kraker, M. D., commanding 303d Medical Regiment, has issued the following General Orders No. 2:

"It is with deep regret that the announcement is made of the death of Lieutenant-Colonel Carlyle Edgar Sutphen, of Newark, N. J., on March 7, 1923.

"Lieutenant-Colonel Sutphen enlisted as a private, First Troop, Calvary, New Jersey National Guard, January 24, 1900. He served as hospital steward, from 1901 to 1903. He received his commission as first-lieutenant and assistant surgeon, October 18, 1903, New Jersey National Guard; resigned, June 18, 1908. Was appointed major, Medical Corps, United States Army, June 13, 1918, and reported for active duty, July 13, 1918, at Camp Greenleaf, M. O. T. C., Chickamauga Park, Ga. Sailed for France, November 11, 1918. He was commanding officer of Base Hospital 123, from November 2, 1918, to July 15, 1919. He was discharged from active service, August 2, 1919. Appointed lieutenant-colonel, Medical Officers' Reserve Corps, November 18, 1919.

"In the death of Lieutenant-Colonel Sutphen the community loses a public-spirited citizen and a physician of marked ability; the service of a loyal and valuable officer. His intelligence and fineness of character endeared him to all who knew him, and the world is the better for his having lived. David A. Kraker, colonel, M. C., U. S. A. (Reserve), commanding."

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ONE HUNDRED AND FIFTY-SEVENTH ANNUAL MEETING OF THE Medical Society of New Jersey

Haddon Hall, Atlantic City, June 21st to 23rd, 1923

THE VICISSITUDES OF A DOCTOR'S LIFE.

*Anniversary Discourse Delivered at the
Anniversary and Dedicatory Meeting
of the Academy of Medicine of
Northern New Jersey in
Newark, N. J.*

By John M. T. Finney, M.D.,

Professor of Surgery, Johns Hopkins University
Baltimore, Md.

The vicissitudes of a doctor's life are many and varied. No one but he knows the full meaning of the intimate personal relationship that exists between him and his patients, the awful responsibilities that he has to bear, the tremendous strain upon his physical, mental and moral resources. It is to a brief consideration of a few of these vicissitudes and their general effect upon the character and qualities of mind and heart of the doctor, that after an intimate personal acquaintance with and observation of him for over thirty years that I venture to call your attention for a short time this evening.

In the first place, the practise of his profession, in addition to the severe physical and mental strain, involves not a little personal danger to the doctor's own health, or even life. How frequently does it not happen that the lay press or the medical journals chronicle the death, in line of duty, of some medical man who has himself fallen a victim to disease contracted from a patient whom he was try-

ing to save? Especially is this true during epidemics of one kind or another. The recent influenza epidemic was a marked illustration of this melancholy fact. The mortality rate among medical men during that epidemic was truly appalling. Worn out by lack of rest and sleep, long hours and irregular meals, to say nothing of the strain upon their nervous vitality, their resistance lowered, many fell an easy prey to this dreaded disease. In addition to all these causes predisposing to infection, the very nature of their calling brings doctors constantly and continuously into close contact with contagions of varying grades of virulence. Happily, nowadays, the dangers from this source are not nearly so great as formerly, thanks to a better understanding of the life history of the various infectious agencies and the usual avenues through which contagion is transmitted,—to more effective methods of quarantine and of disinfection of excreta, etc., and to more rigid antiseptic technique. But even so, and in spite of the advances made in recent years, the doctor must of necessity be more exposed than any other individual to the contraction of disease of one sort or another. The prospective medical student should weigh well this fact before undertaking the study of medicine as his life work, for once he has put his hand to the plough, it is too late to turn back. The truly conscientious physician cannot stop to think of himself or of the risks involved to his own life. He need not be

foolhardy nor recklessly disregard the ordinary precautions dictated by prudence and common sense, but there are occasions that come to every physician when the best interests of his patient, some sudden emergency perhaps, some desperate chance to save a life, may require the utter forgetfulness of self and the abandonment of every consideration, save the paramount one of the patient's welfare. When such tests come, and they do come sooner or later to every doctor, it is the glory of the profession that few of its members are found wanting. The long roll of the medical profession contains the names of many unknown heroes, unheralded and unsung. Hence it is that the average life of the doctor is less than that of the other professions by a considerable amount. But what of that? Better a short life and a busy one, crowded full of service to one's fellow men, than a long life of comparative idleness and unproductiveness.

The doctor's family is often more in need of sympathy than himself. He is busy, and if he is a true physician, he will be absorbed and happy in his work, no matter how strenuous it may be. He soon gets used to his irregular mode of living. He frequently requires, however, the traditional professional gastric neurosis and, doctor-like, worries himself sick over it. Not infrequently sub-rosa, he tries a lot of silly remedies that he would not recommend to his patients, and would be ashamed to have them or his professional brethren know he had tried. Yes, a doctor makes a poor but a very human patient, he is always thinking of the "maybes." He knows enough to appreciate just how little at times he really does know about disease, its causes and treatment. The possibilities, not the probabilities, command his attention. Then, too, he is not a little influenced in this respect by the widespread belief among members of the profession, that if anything out of the ordinary is going to happen, it is very apt to happen in the person of a doctor or a member of his immediate family. Remarkable instances of this are familiar to every physician. So it is that the doctor's family, especially his wife, has a pretty hard time. She has to bear the brunt of the irregularities and the vagaries both of his private and professional life, unless he is fortunate enough to be able to afford a secretary, and not infrequently even then the wife

has to listen to the tales of woe of his women patients, over the telephone, in market, at afternoon teas, at the club and elsewhere. The endless details of the subjective symptoms of the psycho-neurotic are retailed to her and not infrequently she is called upon to advise when the aid of the family doctor is sought in the complications that occasionally arise in domestic affairs. In this latter situation, the wise doctor will soon come to hold in high regard the advice and practical suggestions of his wife, if she is the proper sort. If she is, her virtues will be legion, not the least of which will be tact and the ability to control her tongue. There is nothing quite so fatal, especially to a young doctor's prospects, as to have his wife retail to interested listeners the maladies of his women patients at an afternoon tea or over a game of bridge. Most offences may be forgiven, but this one never.

The patient herself may (such is human nature), and not infrequently does, delight in discussing in detail her own physical infirmities and the number and character of her previous operations and in enumerating the particular parts of her anatomy that she has lost at the hands of the surgeon. But for the surgeon's wife to trespass upon her prerogative and impart any inside information is an unpardonable breach of professional etiquette.

It is a curious fact, and often commented upon, that if a doctor has himself been the victim of a certain malady, forever afterwards is he more particularly interested in that affection, and more sympathetically inclined toward anyone so afflicted. It is a rather fortunate thing, therefore, for a medical man to have had some personal experience with illness, to have himself suffered pain. From the standpoint of his patient's comfort and care, there can be no doubt of this. There is a sort of fellow-feeling established at once between the patient and the doctor who has been through the thing. In this scientific age, the tendency is to make light of such things, to look at disease as a problem and the patient as a thing. The former is all very well, but the latter is to be decried in every way. Unless a doctor comes to look upon every patient as an individual entity, a problem, if you will, but never to lose his individual identity, he will miss that delightfully intimate personal relation-

ship existing between the true doctor and his patient. Through this intimate relationship does a doctor come really to know and thoroughly understand his patient. We smile nowadays when the expression is used which was so commonly heard in speaking of the old family doctor, "he knows his patient's constitution," because he had treated that family for years. But there is not infrequently a great deal in it, especially if, in addition to the knowledge so obtained of physical characteristics and hereditary traits or taints of a certain individual or family one has acquired an insight into the character and knows the workings of his mental processes and his spiritual aspirations. The family doctor is indeed in a position to help that individual as no stranger possibly could.

The average doctor is a very poor business man. He is an easy prey to the get-rich-quick sharks and the numerous other vendors of "gold-bricks" of all kinds. Read over the list of victims of any exploded blind pool or other swindling scheme and you will find the names of a goodly number of doctors, some of them quite likely your friends. The doctor is in most respects an excellent judge of human nature, but when it comes to the sleek confidence man, with mining or oil stock or other similar worthless but highly lauded securities to sell, he is a veritable babe in arms, notoriously "easy." Why this should be so can be readily understood from the character of his training and the traditions of his profession. His business sense is poorly developed and its education sadly neglected. His wife and children frequently suffer in consequence.

A doctor's duties are a strange mixture of the pathetic and the humorous. He is called upon to laugh with those who laugh and to weep with those who weep. In human experience, tragedy is not far removed from comedy, and the humorous and pathetic are not frequently found side by side. No one realizes and appreciates this fact more than the doctor. Fortunate is he who has a developed sense of humor. It often relieves an otherwise trying situation. The speaker was once consulted by a lady dressed in the deepest mourning. Examination and the history of her trouble both strongly suggested the presence of gallstones and the advisability of a surgical operation for their

removal. After this opinion had been stated to her as tactfully as possible, she, with clasped hands and tearfilled eyes, in pleading tones exclaimed "Oh! Doctor, doctor, don't tell me that, you know I have just become a widow and I do so want to live." Not having had the pleasure of the acquaintance of the lately deceased husband, the speaker was unable to surmise whether it was a happy release or other prospects that inspired the strong desire for continued existence.

Upon another occasion a maiden lady of uncertain age consulted the speaker with the history of having received a serious fall, from the effects of which she had since suffered considerably. She seemed exceedingly nervous, and for some unexplained reason was evidently greatly embarrassed and distressed. With some difficulty the speaker finally succeeded in developing the fact that her chief trouble was located in one of her knees. It was then suggested as diplomatically as possible, that it would be impossible to treat satisfactorily the injured member without inspection and examination. After a painfully embarrassing pause, she produced from beneath the folds of a cloak which she wore, a hitherto carefully concealed package, which after some hesitation she proceeded slowly to unwrap, revealing a girl doll-baby completely clothed. Then cautiously lifting the hem of the skirt, she exposed a portion of the doll's bared knee and pointing to a definite spot, remarked "There, Doctor, is where I hurt my knee." Long training and due regard for the lady's feelings enabled the speaker carefully to inspect the doll's knee and prescribe therefor without betraying undue levity. Apparently the vicarious treatment resulted satisfactorily, or possibly it was the fear of subsequent examination and exposure, for a prompt recovery followed.

People of all types of mind and education, or lack of it; of different nationalities and various points of view may or may not be interesting when they are well and actively employed in their various avocations. But when they are sick and abnormal, as they always are under such circumstances, they become not infrequently, most interesting character studies, and with few exceptions present striking similar traits. Thus a doctor sees human nature stripped of all of its

veneer; in some individuals exhibited in all its ugliness, selfishness and shame; in others in all its unselfish beauty, and adorned with many graces and virtues. Then too one will find curious and odd mixtures of all of these virtues and vices. The Dr. Jekel's and Mr. Hyde's are fairly numerous in real life, and illness is a good developer of latent and hitherto concealed traits of character. On the whole, though, while there are some surprises and disappointments, the good in human nature predominates over the bad, and with few exceptions, a doctor finds his respect and admiration for his fellow man, all the while increasing with a better knowledge and understanding of his traits and his temptations, and how he meets them. A more intimate acquaintance with the conditions under which he lives renders the doctor far less inclined to be hypercritical of his fellowman, and far more tolerant than he was before. Invariably the better insight one has into the vagaries of human nature and the strain and stress that is put upon it by the exactions of modern conditions of life, and the present disordered state of society, the more respect and admiration one has for it. One comes to wonder not that there is so much sin and sorrow, so much wretchedness and woe, so much vice and crime in the world, but that there is so little of it. The opportunities that come to a doctor to study individuals under most trying conditions and their behavior under such circumstances in its relation to society at large, is not the least of the privileges that come to him in the practise of his profession. When the doctor comes to view his daily tasks in this light, the drudgery of his professional life becomes transformed into opportunity by the spirit of service, and the self denial and the hardships and the great responsibilities so inseparable from a doctor's life become the crowning glory of his profession. The real man does not want an easy job; he rejoices in difficulties to be overcome, in problems to be solved; they but add zest to his efforts.

But great as are the demands of his profession upon the physical resources of the true doctor, those made upon his mental and spiritual forces are greater still. Particularly is this true of surgery. Here in truth and in deed does the surgeon at times hold the life of his patient in his hand, and no one appreciates the

full significance of this responsibility quite so well as the honest, conscientious surgeon. Loss of sleep, broken rest, irregular meals, long hours, all have their effect sooner or latter in impaired digestion, premature grey hair, a disturbed nervous system, shortened life. But comparatively few, however, are disabled by the hard work. Overwork as such has a low mortality rate. It is worry and responsibility that kill. This feeling of responsibility is very great all the way through. In the first place in the matter of a correct diagnosis. Then what is the proper treatment of this particular case, to operate or not to operate? If the former, what form should the operation take, simple and palliative, or radical and capital? Then in the matter of technical execution of the operation, which of several methods should be employed? Then, most trying of all, am I capable of doing this particular operation in the way I know it should be done, or, in justice to the patient, ought I to refer him to another and more competent surgeon? Then after the operation is done and over, and for some reason or other the patient does not do as well as he should, and one begins to wonder and to get worried and goes over in retrospect the operation, step by step, in order to find some possible explanation for existing conditions. These disquieting thoughts come to every conscientious surgeon to disturb his rest and cause untold worry. Happy and fortunate indeed is that surgeon or medical man who does take his patients to bed with him, but who can, when he lies down to sleep, drop his worries for the night and take them up next morning, where he left them off. Many times, of course, these anxieties do not arise, as fortunately nowadays surgical skill and technique have reached such a high state of perfection that one approaches a surgical operation with far more confidence and assurance than formerly. But even so, when one is dealing with human life, as a surgeon constantly is, one comes to appreciate the absolute necessity for attention to every detail, the slightest infraction of which at times, may be fraught with the most serious consequences. When one is dealing with dollars and cents, as is the case in a business venture, one may entertain a reasonable hope to recoupe in some succeeding venture what one has lost in the preceding one.

But when a mistake is made in medicine and surgery, who pays the price, sometimes with a life? No, in dealing with matters pertaining to human life or even human health and happiness, there may be, and not infrequently is no come-back. Small wonder, then, that the doctor's worries and responsibilities are different from others, and more far reaching in their effect than ordinary ones. Here is where that quality of equanimity so eloquently discoursed upon by the late Sir William Osler, so indispensable in a doctor, shines forth so resplendently as it does in the person and character of certain members of the profession that one has known, both living and dead, notably Sir William himself. It is a quality to be cultivated beyond all else, a jewel without price, the possession of which will do more to make a doctor's life complete and bearable than any other quality. Fortunate indeed is the happy possessor of it in full measure.

"God and the doctor we alike adore,
But only when in danger, not before.
The danger o'er, both are alike requited,
God is forgotten and the doctor slighted."

The unknown author of these lines must have been a doctor, and must have penned them in a moment of despondency, such as comes now and then to every doctor. Especially is this true after he has had dealings with a certain class of patients familiar to us all, most exacting and insistent in their demands upon our time and attention, most indifferent to the claims of others when they themselves are ill, or imagine they are, which is often more to the point. But when they are recovering and think themselves safe, they are ever prone to become most forgetful and unappreciative of past services rendered. Fortunately, however, all patients are not like this. For every medical man here, I am sure, is familiar with the genus "G.P.," otherwise known as a "grateful patient." He or she, more often the latter, is the best and cheapest advertisement that a doctor has. There is no counterpart to the "grateful patient" in any other profession. She is a great and unique institution. What would a doctor do without her, (for the most militant type is always of the gentler sex), to fight his battles for him; to stand up for him through thick and thin; to defend him

against the verbal assaults of the grateful patients of his professional rivals; to advertise him and his virtues, real and fancied, at every afternoon tea and in every sewing circle or club of which she is a member? It would be difficult to imagine practising medicine without her. The doctor's office and home would be far less well furnished; his library bookshelves less well filled with popular volumes; his personal wardrobe less striking and complete but for her.

The character and extent of the professional service may be and frequently is entirely disproportionate to the gratitude of the patient. But that makes no difference. For the last 15 or 20 years, the first reminder that the speaker has had each year of the approach of the Christmas season has been in the shape of some little gift from a poor widow for whom he had removed a tiny wart from the side of her nose. The wart had been so situated that every time she opened her eyes she saw it and from its nearness to the eye, it looked as big as a house to her. Her gratitude was correspondingly great. Upon one occasion another "G.P." of the speaker evidently somewhat disturbed and doubtful in her mind, asked him if it really was true that he had ever laughed while performing a surgical operation. He replied in the affirmative and added that he was glad when he could find something to laugh at, as it relieved the nervous strain which at times became very great. He then inquired why she asked the question, feeling sure that there must be a reason. She replied that recently, at an afternoon tea, Mrs. X. had come in all aglow with excitement, saying that she had just been calling at a friend's home when someone had run downstairs and said there was a surgical operation going on in the house across the street. So, of course, they all adjourned upstairs, where they could get a better look, and sure enough, there was Dr. F. to be seen in the act of operating upon someone. Said Mrs. X. "We could not see what he was doing, but right in the middle of it he looked up and laughed. The idea of such a thing! No hard-hearted, cold-blooded doctor like that could ever touch me." "Then," said my former patient, "we almost came to blows, for I could not sit still and let anybody say anything against my doctor and not defend him whether he was right or wrong. But I wondered afterwards

weather you really had laughed or not." Such is the exaggerated and erroneous interpretation that is at times placed upon some innocent and harmless word or action of the doctor through misapprehension or the distorted imagination of the patient, or, more often, the patient's friends. The doctor and the preacher, perhaps, more often than any other callings, thus suffer. They not infrequently would be justified in uniting in the joint prayer to be delivered from their friends.

In that charming sketch by Sir William Osler entitled "The Evolution of Modern Medicine" (which every medical man, graduate or undergraduate, should keep always at hand) he quotes Lucretius, Pliny, Celsus and others, to show the origin of primitive medicine. Medicine arose, says he, out of the primal sympathy of man with man; out of the desire to help those in sorrow, need and sickness.

In the primal sympathy

Which having been must ever be;

In the soothing thoughts that spring

Out of human suffering.

The system of medicine in practice to-day is but the gradual accretion of observations and discoveries and the deductions that have been made throughout the ages. The doctor, like the system of medicine, is the product of a gradual evolution by slow and painful stages up to the present high position of responsibility and influence occupied by him in the community. This progress has been punctuated here and there by epoch-making discoveries, while in between are to be found melancholy stretches barren of all signs of intellectual activity and growth. But slowly and surely there has been evolved a system of medicine founded upon careful observation, scientific experiment and research and correct deductions therefrom, the truth of which has been repeatedly demonstrated beyond peradventure of a doubt. And yet what do we see, not once but frequently, namely, the melancholy sight of people of more than ordinary intelligence about most matters chasing after strange gods in medical matters. There are few things that people act more foolishly about than in matters which pertain to their health. The astonishing thing about it all is that the more ignorant and foolish the fake doctor, and the particular cult that he advocates, and the more absurd the line

of talk concerning the diagnosis and method of treatment of the real or fancied ailment, the more readily does our supposedly intelligent and educated man or woman swallow it all. There are, of course, many exceptions to the rule, but President Lincoln and Mr. Barnum (of circus fame) were excellent judges of human nature and as commonly reported were not far wrong in their general estimate of it, namely, "that most people can be fooled, and many like to be."

The day of bread pills and other placeboes is fortunately past, although patent medicines, "favorite prescriptions," the mental healer, the osteopath, the chiropractic, Dr. Coue, and Christian Science, that bastard offspring of an unholy alliance between pseudo-science and false religion, are still with us and flourishing like the green bay tree. These and countless other fake systems of medicine, the so-called bloodless cults, together with the various societies of the anti—anti-vaccinationists, anti-vivisectionists, and so on—will continue to flourish until the general public becomes sufficiently educated to be able to distinguish the difference between the trained physician who knows his limitations and is honest enough not to claim to be able to do more than he can do, and the ignoramus, the charlatan or the quack who does not know enough to know his limitations, and is likewise dishonest enough to make extravagant claims at variance with known laws of health and disease, many of which have been incontrovertibly established from time immemorial. But in all candor, it must be admitted that these cults are not wholly due to ignorance upon the part of people generally to the fundamental laws of physiology and pathology. The Medical Profession itself must bear its share of the blame for their existence, by its failure to take proper notice of and interest in many of the subjective symptoms of which patients complain. A patient may complain of a pain here or an uncomfortable sensation there, while a most careful physical examination by a competent physician reveals nothing at all out of the normal. It is so difficult, as every conscientious physician knows, to diagnose, advise and treat such cases properly. On the other hand, it is so easy to say, as the Christian Scientist says with that beatific smile, so characteristic of the cult, "It is nothing, these

fancied disturbances are due simply to error" and will promptly disappear after "getting one's mind into proper relationship with the source of Divine truth," or some other similarly senseless formula. Or these disturbed sensations are often attributed, as the osteopath and the chiropractor does, to "pressure of a misplaced or dislocated vertebra" or some other equally senseless or absurd cause. The honest, intelligent physician cannot take refuge behind such subterfuges. When pressed for an explanation, he must frankly confess his ignorance of the true causes. Many of the unthinking public thus become dissatisfied and keep going from one physician or cult to another, until they find someone who will give them a glib explanation of their troubles, no matter how silly or impossible, and a guarantee of a cure. It is the failure therefore on the part of reputable educated physicians to take due cognizance of these disturbing, often distressing, subjective symptoms that has left this large class of sufferers a prey to all sorts of cults and irregular practitioners. It would be idle as well as untrue to say that many of these unfortunates have not been benefitted and even cured by some of these strange practices. What many of these people most need is someone who will be interested in them; who will take the time to listen to their tales of woe, real or imaginary, someone who can in some way inspire sufficient confidence in them to make them follow implicitly what they say and then to believe that it will cure them. The rest is easy, and the particular method of cure relatively unimportant. When the medical profession as a whole awakens to the necessity of giving more attention to subjective symptoms, the result often of functional disturbances not readily or even possibly recognizable, the harvest for the large army of cults, quacks, Christian Scientists, and other irregular practitioners of medicine will be over. Fortunately for the welfare of mankind and to the credit of the profession, signs are not wanting that the more enlightened among them are beginning to give this large class of unfortunates the attention they deserve, and subjective symptoms and functional disturbances are now coming in for a large share of study and attention.

The regular medical profession is not simply a school of medicine, it is a vast protective force, an army organized and

recruited for conflict with disease and for the preservation and restoration of health. It asks no favors of the public which it aims to serve. It seeks no personal benefits as such, indeed it is constantly working against its own professional interests, to limit the spread and activity of disease. All that it does ask, and it asks it as a right, not as a favor, is that it should be allowed to minister to the needs of the public and private health along proven and well established scientific lines, unhampered by foolish and reactionary cults and the various societies of the "antis." It asks, if these various so-called bloodless cults are to be permitted to practice medicine in the community, that they be first compelled by law to conform to the same general standards of education and training as are required of the regular medical profession. It asks further, because of special training along these lines, to be consulted in all matters of legislation concerning public health, and, furthermore, it asks the moral and financial support of all good citizens in increasing the endowments of hospitals and medical schools and in furthering such worthy objects as that for which we are gathered here tonight, in order that they may be better able to provide for the needs of the public in the way of thoroughly competent educated physicians.

"From a study of conditions past and present, we must conclude that disease is an antagonist of man that has stimulated his activities throughout the ages, and that the causes of disease are enormous, insidious forces whose unrelenting and pitiless attacks will continue to harass and discipline man until his intellectual, social and spiritual faculties shall have developed to such a degree that he can overcome these enemies, as primitive man finally overcame the more obvious enemies that endangered his life. The problems unfolded for today are sufficiently difficult to test the metal of an advanced civilization. Take for example, the control of tubercle bacillus. It involves stupendous questions of sociology, government and finance. It is a problem to tax the highest intellectual faculties of man and its solution requires a high degree of intelligence, energy and unselfishness on the part of individuals and communities, and a thorough system of education.

The knowledge of the causes and means of prevention of disease that has been

acquired during the past fifty years is greater than was the sum of all previous knowledge, and not yet has there been time for it to diffuse through the minds of the masses to become crystallized into laws of health.

But this diffusion through education must take place before a very successful war against the insidious enemies can be waged. Behind the laws of health, there must be an educated and intelligent public."—(Brem).

Control of many diseases is obtained through control of environmental conditions, that is, by sanitation. By far the greatest progress in preventive medicine has been obtained in this direction by purifying the water and milk supply, proper disposal of sewage, the reduction of the number of mosquitoes, war on rats and other rodents, the control of lice infection, muzzling of dogs, etc. There is, however, another great group of diseases in which sanitation is largely ineffectual,—the group of communicable or contagious diseases. These must be controlled chiefly through man's education and his control over himself, as their prevention depends largely upon early recognition of infected persons and their voluntary isolation or quarantine. Some of these, smallpox, diphtheria and leprosy, have been brought largely under control but others, such as tuberculosis, while much progress has been made, still resists effectual control. Pneumonia, for instance, although the organism causing it was discovered years ago, has nevertheless, so far, successfully resisted all efforts to conquer it.

That there is a crying need for the exercise of preventive medicine along other lines than those just mentioned, is emphasized by the fact that the medical examinations made during the draft for the United States Army during the great war showed over thirty-three per cent. of men in the draft age to be physically unfit for military service. A study of these disabilities revealed that the great majority of them could have been prevented by judicious medical care and education during early life, especially during the school age. This emphasizes the fact that the medical care and hygienic education of the school child are perhaps the most imperative duty that confronts the present generation. And yet this duty is strenuously denied and its fulfillment obstructed in various parts of the country by an ill-

informed league of theorists who are attempting to check in every way possible the effective carrying out of the public health work in the schools. These same methods of preventive medicine applied during the war for the protection of our Army were so successful that our death-rate from disease was lower than that in any previous war. It is the first war, in fact, on record in which disease has killed fewer of the combatants on the field than were slain in battle. The records show that in the American Expeditionary Force disease killed only about one-third as many soldiers as died from battle wounds. And yet, in the face of all this undoubted evidence of the effectiveness of the methods which have been so effectually employed in the prevention and cure of disease, both in peace and war, we are confronted today with the extraordinary spectacle of large bodies of supposedly intelligent men and women who are using every effort to obstruct and prevent the employment of these methods in the control and prevention of disease, which means, in turn, the prevention and relief of untold suffering and the saving of countless human lives.

The conception that animates the modern scientific minds at the present time, namely, that the cure of most diseases lies in the remarkable defensive and offensive reparative mechanism of living tissues, is of far reaching importance. Upon this conception, the physician's role is chiefly to support the body in its fight against disease and to render every aid possible. The role of drugs in the practice of medicine is now a subsidiary one, chiefly, but not wholly, palliative. There are some diseases, not many, to be sure, which can be cured by drugs. Quinine in malaria and salvarsan in syphilis, are examples. In spite of the enormous work that has been done, there still remains many problems which have, so far, baffled science and whose solution will be fraught with the greatest possible benefits to the human race.

There is, perhaps, unfortunately, a tendency in the modern trend of medical education to over-emphasize the scientific side of the student's training and to neglect the more strictly personal and practical side. The student is left to find out that for himself, when he gets out into practice.

Perhaps this is all right, since the

tendency all the while is for the sick to go more and more to the hospital for treatment. But it will be a long time before the bulk of the doctor's practice will change from the home to the hospital. One potent reason for this will be the matter of expense. The average patient cannot afford to be ill in a hospital. It is a luxury quite beyond his means, even in these extravagant days. With the cost of a private room in the hospital, the expense of one or more trained nurses and various incidentals, to say nothing of the doctor, who always comes last on the list, few can afford it.

It will be a sorry day for humanity if the type of general practitioner, the family guide, philosopher and friend ever becomes extinct. The world and society in general will be the loser. He may not know so much medicine, he may not be able to recognize and call by name many of the rarer and more modern differentiations of disease conditions, but he has something else that the individual needs and that nothing else quite supplies.

There comes into my mind the picture of a country doctor of the old school whom in the earlier years of my life it was my privilege to know. His practice covered a radius of twenty miles in a typically rural district, in those days before the automobile, a large area, and he knew every part of it. He covered this area always on horseback. He was an excellent horseman and his horses were of the best-blooded stock. He was fond of fox-hunting and was noted for his skill as a rider and huntsman. He preferred to ride by night, choosing by-paths and short cuts, not bothering to follow public roads or to stop to open gates, taking fences and ditches at a leap. He seemed to know every individual, black and white, in his district, calling most of them by their first names, and having brought many of them into the world. He was consulted upon all matters, public and private and not alone professional, from politics and religion to the most becoming color of ribbon on the baby's new bonnet. All advice was given and suggestions made in the same kindly and interested way. A sympathetic hearing and helpful and cheering answer were assured to all persons and all queries. He early became engaged to a young and beautiful girl in the neighborhood, and the wedding day had been set. Shortly before it, she re-

ceived a severe fall and suffered an injury to the spine from which in those days there was no known cure. She took to her bed and remained bed-ridden for over forty years. During all these years, up to the beginning of his fatal illness, he remained constantly faithful, a devoted lover. Every day, with few exceptions, due to the exigencies of his practice, he found time from his busy life, by day or by night, to ride the four miles which separated his home from hers, to bring her a flower or a book, some little token and a word of cheer for her loneliness. Meanwhile, he was giving his life and all that he had to the constant care of his fellows in that community, gradually growing old and feeble in their service. Small wonder then, that at his funeral, which I attended and which was one of the most impressive experiences of my life, held in the quiet country church-yard just at sunset, his one request, of a beautiful autumn day, there gathered an outpouring of people from the entire country side, such as had seldom been known before. The manifestation of grief and loss upon all sides was so spontaneous and genuine that one could not but feel that that community had lost its best friend and felt the loss most keenly. It was the natural and universal thought and desire to show in some small measure their appreciation of their beloved physician and faithful guide and councillor that prompted that community to erect, by popular subscription, a plain unpolished granite shaft, indicative of the character of the man, upon which was inscribed these words:—

"This shaft is erected by an appreciative and grateful community to stand as an enduring memorial of a noble life adorned with service and crowded with love."

Humanity is one of the chief characteristics of the true doctor, and one of the crowning glories of a profession most exacting in its demands upon the time and talents of its members. It is this human element, this call to the service of his fellow-men, wherein lies the charm that appeals so strongly to the true physician. The joy and satisfaction experienced in relieving the ills and ministering to the wants of humanity more than compensate him for the loss of the larger social and pecuniary returns that come from other less onerous and responsible vocations. The true physician is supreme-

ly happy in his work. He could not be happy doing anything else. Speaking out of his wide experience of the satisfaction that came to him in his work, the late Dr. E. L. Trudeau, himself a sufferer for most of his life from the great white plague and speaking from the standpoint of the physician, says: "To look about me on those whom I have helped in the hour of need and, even though in a very slight degree, to have been instrumental in restoring many to health and active lives of usefulness, and to feel daily their gratitude and love, is a joyful heritage indeed, which endures in a word where all else passes away, and which brings some contentment and peace in hours of physical misery and discouragement." In this connection, the word of Robert Louis Stevenson who, from his long illness and the resulting need for medical service and his consequent more or less intimate association with medical men, renders him peculiarly well fitted to speak from the standpoint of the patient, says: (I am quoting the substance of his tribute, not literally).

"There are men and classes of men who stand above the common herd; the soldier, the sailor and the shepherd not infrequently; the physician almost as a rule. He is the flower (such as it is) of our civilization; and when that stage of man is done with and only to be marvelled at in history, he will be thought to have shared as little as any in the defects of the period, and most notably exhibited the virtues of the race. Generosity he has, such as is possible to those who practise an art, never to those who drive a trade; discretion, tested by a hundred secrets; tact, tried in a thousand embarrassments, and, what are more important, Heracleian cheerfulness and courage. So that he brings air and cheer into the sick-room, and often enough, though not so often as he wishes, brings healing."

Says Richard Cabot,—

"The physician is the child of his age. Such an opportunity as a great painter had in the Renaissance or a great musician had in the early years of the nineteenth century, a physician has today. The scientific and mechanical, the utilitarian and practical eagerness of our age, finds an outlet in him. But the deeper and more permanent hungers of the human race, the search for truth and to spread it, to love and serve our fellows

and to know God, also find their natural expression and development in the practice of medicine. It brings few to fame and renown. It is hard work, never finished in any eight or eighteen hours a day. But its rewards, as I see them, are beyond those of any other profession."

THE EFFECT OF PREGNACY ON TUBERCULOSIS.

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Among the exciting causes responsible for converting tuberculosis infection into active tuberculosis disease among females there are perhaps none that play so important a part as does pregnancy, parturition and lactation.

In presenting this subject for your consideration, we are mindful that nothing that we have to present this evening in any way elucidates the subject generally, but if in submitting to you an analysis of our own findings, coupled with the opinions of those who are most concerned, and whose authoritative opinions deserve respectful consideration, we are confident that the resulting discussion will benefit us all, particularly the writer, who has given much thought to the subject, for the reason that, in an official position, we are often called upon to decide questions of great moment, which concern the tuberculous pregnant woman.

Like most topics, we find the extremists on both sides of the question. In our service, we have observed, very frequently, that, during the course of pregnancy, many women are, apparently, improved. This was largely observed among women with the fibroid type of phthisis. Hence, but a short time ago, physicians advocated that tuberculous women become pregnant, as a therapeutic measure.

In the early years of our connection with the local institution, the importance of pregnancy, as an exciting cause of the disease, was not given the consideration it deserved. During the past five or six years, however, we have closely observed the relationship that pregnancy has upon tuberculosis, and we have become convinced that the condition of the tuberculous woman, practically always becomes aggravated and that the tuberculosis process generally becomes activated, even if previously inac-

tive, excepting in the completely arrested or cured, or, occasionally, in the fibroid type, previously alluded to. More recently we have had opportunity to observe a series of cases in our service, who, in time, were transferred to the obstetrical division of the Jersey City Hospital and subsequently returned to us; in all of these cases we found aggravated physical signs and concomitant symptoms.

A research made for us, in the literature and questionnaires submitted to some of my colleagues in tuberculosis institutions of the country, reveals in part, the following: Trembley, of Saranac, in a series of 240 cases, had 151, or 63 per cent., who said that tuberculosis originated, or at least was first discovered, after the birth of a child. Turban, of Schauta's Clinic, reports that 20 per cent. of tuberculosis women observed by him, gave a positive history of disease originating or becoming definitely recognizable during pregnancy, or the puerperium.

Fishberg states that of 286 tuberculous married women under his care, 107, or 37.4 per cent., claimed that they had no pulmonary symptoms until one or more childbirths. In a series of 337 cases, studied by P. Jacob and Pannwitz, 25 per cent. traced the origin or aggravation of the disease to pregnancy. Scarborough reports ninety-four, or 47 per cent. of 200 married women, admitted to the Iowa State Sanatorium, in whom the active symptoms appeared after childbirth. Douglass and Harris found that out of 300 women, with a history of pregnancy, admitted to the Ohio State Sanatorium, eighty-eight, or 29 per cent., gave definite evidence that pregnancy was the leading factor to which the onset of tuberculosis might be attributed, and in the twenty-four additional cases, or 8 per cent., it was a presumptive factor, making a total of 37 per cent. of patients in whom pregnancy was a contributory cause of tuberculosis.

The effect of tuberculosis on the course of pregnancy is practically nil. However, it is reasonable to believe that the tuberculous woman may suffer to a greater extent, from the various disorders of pregnancy, than will her more healthy sister. The greatest danger is during labor and the puerperium, when sudden death may occur at any time from cardiac failure, pulmonary hemorrhage or pulmonary edema.

Effect of Pregnancy on Tuberculosis.—In cases of known tuberculosis there may

be an increase of gastric symptoms during the first trimester. During the second trimester a considerable percentage of these patients show a definite improvement, due to the increased metabolism, and some continue to term without evidence of decline. During the last trimester, however, many of the patients lose strength with an alarming rapidity and may die at any stage of labor or the puerperium.

Statistics indicate that existing tuberculosis is usually aggravated by pregnancy. Lohentine states that 38 per cent. of the tuberculosis patients at the Lying-in Hospital, of New York, were seriously effected by parturition. Diebel believes that 64 per cent. of tuberculous women are badly influenced by pregnancy. Bardeleben writes that, from the communication of fourteen physicians, 71 per cent. of tuberculous women grew worse from parturition and that 47 per cent. of the active cases proved fatal. McSweeney and Wang report eighteen childbirths at Sea View Hospital. In their summary, these authors state that during pregnancy, 10, or 55.5 per cent., seemed to retrograde; 5, or 27.7 per cent., to improve, and 3, or 16.8 per cent., were apparently unchanged. After labor, of the moderately advanced cases, seven were improved; of the far advanced cases, 5 or 45.5 per cent., died; 1, or 9 per cent., improved, and 5, or 45.5 per cent., retrograded. This series, while very small, is valuable, owing to the careful hospital treatment.

Under present conditions, it may be estimated that about 33 per cent. of the tuberculous women, who become pregnant, die in less than a year after delivery. These percentages are considered low, in some instances, for Fellner is of the opinion that the tuberculous process, in pregnant women, is accelerated 68.5 per cent.; Kamina contributes 80 per cent. to this cause; Pradella, 90 per cent.; Pankow and Kupferly, 94 per cent., and Rostorn, 100 per cent. We believe that the difference of percentages is largely due to the various stages of disease and to its activities.

There are numerous factors responsible for the aggravation of tuberculosis during pregnancy. As it makes an increased demand upon metabolism, oxygenation and innervation on circulation and elimination, resistance of a quiescent pulmonary lesion often breaks down. The presence of the pregnant uterus interferes with respiration and the proper aeration of blood. The nausea and vomiting of pregnancy tend to

interfere with assimilation. The prolonged muscular exertion of labor, the loss of blood and the attending exhaustion, the use of the anesthetic, auto-infection by the aspiration of infected material into healthy portions and the general diffusions of toxins into the system are all factors that must be considered, together with the fact that the strain of subsequent lactation and the care of the child play an important role.

Experience thus having established the fact that in 40 to 45 per cent. of married tuberculous women, the onset of active disease is attributable to pregnancy, it is reasonable to anticipate the question of prophylaxis. Auward, summarizing upon the situation, says: "The young tuberculous girl should not marry; the married woman should not conceive and the mother, should not nurse her child." This dictum is entirely too general and should not prevail. What then should be our attitude? This attitude might be considered from the point of view of the phthisiologist or internist, and that of the obstetrician and gynecologist, and even here we find opinions somewhat divided. Three groups have been described by Schauta: The first is the school that says: "Abort every woman that has tuberculosis;" the second: "Abort no woman that has tuberculosis; give her the best of treatment and let her go through her pregnancy;" the third school, and this seems the most sensible, holds that every case must be treated individually.

Termination of pregnancy, subsequent to the first trimester, has shown such a high mortality that it has been discontinued. Many of the men consulted seem to be adverse to the emptying of the uterus during the first three months. Experience has shown that many of the women so treated have a rapidly fatal course. The shock of the anesthetic and abortion may do as much harm as that of labor. Bacon finds that collected results of therapeutic abortions are not favorable, and does not consider abortion justifiable in over 10 per cent. of the tuberculous pregnant women.

Veit reports that there was no improvement following abortion in 43 per cent. of the cases collected by him. Trembly, who, at Saranac, with patients under most favorable conditions, has, perhaps, aborted more women, because of tuberculosis, than any other physician in the United States, has not seen enough improvement to warrant the establishment of a general rule. V. Bardeleben states that 50 per cent. of his cases died after the pregnancy had been terminated by abortion.

With these statistics before us, coupled with the fact that our own experience has shown the advisability of extreme conservatism, we must conclude that the operative interference should not be resorted to in any case where gestation has gone beyond the fourth month, and in the earlier cases only in those patients where a careful study of the case, both of the history and the clinical findings indicate but slight involvement, very little toxemia and a fairly nourished woman without any complications, particularly laryngeal or intestinal.

It is evident as our experience has only too frequently proven that anesthesia per se plays a very important part, as an existing cause in the reactivation of a tuberculous condition, hence ether should never be used and gas oxygen is the only anesthetic ever indicated.

From time to time, we have given an affirmative opinion relative to operative interference and thus far have not had occasion to regret this step, but, in general, this practice is not advocated. Particularly is such operation with joint sterilization to be deprecated. Interference, on account of advanced disease, because of our desire to save the life of the mother, is never indicated, for the stress and strain incident to such procedure is very severe and is always followed by pronounced activation of the tuberculous process. Aside from this, we must never forget the moral issue, firstly, because of this, and secondly, because we can never be even reasonably sure that good results can be obtained and mother or child, or mother and child, best served, it seems to us that extreme conservatism should govern our final decision.

We know of some very advanced cases reported to us, for instance, a case in Dr. Jaffin's service, where a woman with a large cavity and active pulmonic disease, after treatment at a sanatorium, married, subsequently became pregnant and was delivered of a strong and healthy child.

This brings us to the consideration of the child, firstly, is it, of necessity, born below par, because of a tuberculous mother, and secondly, what should be our attitude relative to the feeding of such a child?

The first question brings up the question of heredity and the plausibility of placental transmission of infection to the infant. The number of cases quoted in literature is so small that it becomes a negligible factor, and we still maintain our belief, which is generally upheld, that there is no heredity in tuberculosis, except a heredity to predisposition.

Speaking broadly, we would say, then that it is perfectly possible for tuberculous woman to give birth to a non-infected child, and that such a child can and frequently does grow to maturity, even without ever demonstrating signs of infection. For several years we have had under our care a child born of a mother who had advanced tuberculosis, which disease eventually caused her death. After her birth, the child was separated from her mother and is now four years old, and, whilst she is not a big child, is normal in every particular and has, at no time, responded to tuberculin tests. Of course, a mother who will not co-operate, is sure to infect a child, but if the proper precautions are exercised and the necessary safeguards thrown around such a child; it is perfectly possible for such a child not to become infected.

In so far as feeding is concerned, we will admit a decided change of heart. The great majority of men, fearful of infant infection, are favoring the immediate removal of the new-born infant from its mother and advocate artificial feeding, this, of course, is what has been done with the cow, but quoting Minor, in a recent discussion on this very subject: "It is well to remember that a woman is not a cow, though too many of our enthusiasts forget that our patients are not laboratory animals, but human beings with souls and hearts." So, in deciding this question, let us consider the human side, primarily—let us then permit the mother to feed her baby, under most careful supervision; let the baby be brought to its mother at feeding time. The intelligent mother will, if instructed not to cough without covering her mouth, co-operate. She will understand the meaning of droplet infection and not endanger the life of her child by kissing it; with such precautionary measures, we can reasonably expect to rear children fed at the breast of their tuberculous mothers.

Hess and many other students of infantile and childhood infections have taught us and proven the great danger to infants exposed to such infection and the great ease with which such infection is accomplished.

Anticipating some surprise on the part of many, because of our apparent change of mind, relative to our attitude in this regard, we desire to say that Leon Bernard, of the Laenec Hospital, in Paris, has demonstrated to our satisfaction the fact that in a series of 100 infants, born of tuberculous mothers (patients in said pri-

mary), such infants were brought at the regular feeding times to their mothers, who, of course, were dressed in sterile gowns, provided with sterile gauze masks to protect the infants from the spray of the cough, and, in none of these cases, after frequent testing, could infection be demonstrated. Having seen the satisfactory results and having heard the discussion by the majority of the men who constituted the last International Congress Against Tuberculosis, held in Brussels, we feel justified in saying that wherever perfect control is possible there the infant ought to receive the benefit of its mother's milk, and the mother, in turn, be granted the happiness incident to this maternal function. Of course, in the event of active, advanced disease, where we can reasonably anticipate the strain of lactation and its influence upon the tuberculous process, breast feeding must be interdicted. Naturally, the hospital, not the sanatorium, is the best equipped for the careful carrying out of such plans, and yet, equally good results can, likewise, be accomplished in the home, if intelligently supervised; in either case the full and complete co-operation of the mother is most essential to accomplish good results. The mother and nurse, or relative, must be carefully instructed relative to the minutest details and the danger of infant infection made perfectly clear, in order to have good results.

There remains just one point that ought to receive our consideration in connection with this subject.

The query which has been submitted to us again and again and which has caused serious reflection and many uncomfortable hours: "Shall a tuberculous woman marry?" In the male, of course, the risk is not so great, but in the woman, the risk is deserving of the most critical study.

In the foregoing pages we have attempted to show the stress and strain that pregnancy have on tuberculosis, and, after careful analysis, we agree with Fishberg and others in saying that indiscriminate prohibition of marriage and maternity to tuberculous patients is unjust; of course, in active or in acute cases our verdict should always be against marriage, but there are cases of healed or latent tuberculosis where the economic and social conditions are favorable, particularly in the more intelligent group, where it is entirely feasible to anticipate no unsatisfactory results from such a union, in which we may feel fully justified in giving an affirmative answer.

The question of transmitting tuberculosis to the healthy husband is one deserving another moment of our time, and, in view of the more or less largely accepted theory of childhood infection, we would say that we do not believe that the healthy consort is apt to show manifestation of disease, because of marriage to a woman, who, in some time during her life, had tuberculous disease, which had become arrested or cured, and we are of the opinion, corroborated by statistics, that we may safely advocate marriage, under these circumstances, without any risk whatever.

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RENAL INFECTIONS IN PREGNANCY.*

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Infections of the kidney form a most interesting and at the same time important complication of the pregnant woman. Three distinct types of infection may be described, depending upon the underlying cause and the type of the infecting agent. Two of these have no particular bearing on the association of pregnancy and are found in the usual type of renal infection anywhere. The third type is the most frequently demonstrated and occurs in about 90 per cent. of the renal infections in pregnancy.

The first type is that of pure infection from pus foci in other parts of the body, particularly the teeth, tonsils, sinuses, furunculosis. This is the rarest kind of all and was not discovered in any of my series of cases. Such conditions are caused by the various "cocci" infections. They show a predilection for the cortex of the kidney, and their terminal pathology is evidenced by numerous cortical abscesses and subsequent perinephritic inflammation, which may progress to suppuration. This is the type so well described by Hugh Cabot¹, and is proven by him to be hematogenous in origin. It is perfectly feasible to have this type associated with pregnancy, and is so described by Parmenter².

The second type is that associated with pre-existing renal, or renopelvic disease. It may be called a chronic pyelo-nephritis, and may be of varying degrees of severity. Under this heading we would group tuberculosis of the kidney, stone, tumor, pyonephrosis and hydronephrosis. With the possible exception of a few cases of the latter, all these are associated with a distinct pyuria. Obviously the superimposition of pregnancy upon these conditions will create a marked and distressing increase in effect upon the patient. Particularly is a hydronephrosis liable to become infected and at once cause extreme symptoms.

The second type is characterized by a mixed variety of infecting organisms. Five of my series were of this type. Staphylococci, streptococci and the colon bacillus were all present in each case.

The third type is one in which the renal pelvis and ureter are the chief points of infection, and the colon bacillus the main infecting organism. The various "cocci" do not easily permeate the secreting tissue of the kidney. They lodge in the cortex with resulting pathology, while the colontyphoid group easily permeate the functional portions of the organ and find a resting place in the renal pelvis. From this point the pathology varies entirely, in my opinion, upon the question of urinary drainage. If this is not interfered with, the infection passes off without much trouble, but if causes acting to prevent such drainage are present, then very decided symptomatology is at once evident. Absorption from the renal pelvis is very rapid and profuse. Substances find their way back through the renal parenchyma and into the blood stream with great readiness. This has been conclusively proven by Weld³, Burns⁴, Magoun⁵ and in our own laboratory. Phenolsulfonephthalein injected in the pelvis of one kidney, through a ureteral catheter, will make its appearance from the other kidney in five minutes—which corresponds with about the normal time when injected intravenously.

The method by which the infecting organisms gain entrance to the upper urinary tract have been investigated and discussed to considerable extent, and are, correspondingly interesting, but not conclusive.

Cabot and Crabtree⁶ maintain that the infection is always hematogenous. Eisen-drath and Kahn⁷ carried out a series of experiments tending to show the great pos-

*Read at a meeting of the Hudson County, N. J., Medical Society held April 4, 1922.

sibility of ascending infection along the lymphatics of the ureter. Ascending infection through the lumen of the ureter is possible, probably only where peristalsis of the ureter has been destroyed by extreme dilatation or infection. Lymphatic infection from the lower genital tract, as well as from the direct lymphatic connection, between the kidney and colon, are, of course, very possible. The usual type of pyelitis being that one caused by the colon bacillus; it would rather seem feasible that the large bowel was the principal source of infection, and that the blood stream and the direct lymphatic anastomosis, between the bowel and kidney, were the principal carriers.

It would seem that most observers were in accord about the symptoms, mode of onset and general course of the pyelitis of pregnancy. All agree that it occurs suddenly, coming on about the fifth to the eighth month of gestation, that it is characterized by chills, temperature and pain in the affected side, with rigidity and some amount of dysuria. Most observers note the greater frequency of right-sided symptoms and the occurrence in primipara more frequently. This latter is denied by Webster⁸, but in my own series, as well as those of the literature, invasion of the right kidney was observed four times more often than the left.

The etiological factors concerned in the occurrence and symptomatology of this disease are most interesting. Why do we have pyelitis in pregnant women more frequently than in non-pregnant? Why is it usually confined to the right side? Why does it attack primiparae? These questions can only be answered by condensing the findings of various observers. Stadfeld, in sixteen autopsies on pregnant women, found the ureters dilated in nine. Olshausen, in thirty-four autopsies on pregnant women, found dilated ureters in twenty-five. In thirteen there was bilateral dilatation, and in twelve unilateral. Of the twelve unilateral, ten were right-sided and two left. Thus it would seem that dilatation of the ureters was by far the outstanding factor in the etiology of the pyelitis of pregnancy. Is this dilatation of the ureters caused by pressure of the pregnant uterus? Bearing in mind the fact that the usual type of the pyelitis of pregnancy does not manifest itself until after the fifth month of gestation, one would be inclined to that impression, but all obstetricians do not agree on this point. De Lee⁹, notably, claims the ureteral dilatation to be caused by kinking

and torsion, due to enlargement and dislocation of the pelvic organs. Until some more scientific method of determining the true etiology of the disease is advanced we must be satisfied with a mere perusal of the facts, as we know them. There is dilatation of both ureters in nearly all pregnant women, with greater distention usually of the right one. This occurs without pyelitis or any pus infection. If these ureters are dilated there must be some cause acting to stagnate the flow of urine through them. Residual or stagnant urine will undergo decomposition and fermentation, with consequent bacteraemia. This becomes a fertile field for infection, and as there are usually colon bacilli seeping through the kidney in nearly all pregnant women, a true pyelo-ureteritis is soon developed.

The greater tone to the uterine and abdominal walls in the primiparae is no doubt the cause of the greater frequency of pyelitis in the first pregnancy. The pyelitis of multiparous women is practically always a long-standing condition, with pathology running back to former pregnancies, or due to type 1 or 2, as described before. In twenty of my series of ordinary colon bacillus pyelitis in pregnancy only four were in multipara, and in one of these the disease was post-partum.

Although the symptoms of the disease are more pronounced upon the right side, still nearly every case of mine showed pus cells in more or less quantity from the left ureter; proving that if interference with the outflow of the urine would be established in the left ureter that this side would show as acute symptoms as the other.

Symptoms—In my series the symptoms were clear-cut and well defined in the third type of infection. Usually there is a period of slight frequency and dysuria. Then follows a chill, temperature, severe pain in the affected side, vomiting and a rigid, distended abdomen. This continues in an intermittent manner, depending entirely upon treatment and the severity of the disease. In the early stage of the infection there is probably very little actual renal involvement, as my own opinion is that this condition is due to infection of more or less residual urine in the ureter and renal pelvis, and that the symptoms are caused by absorption of toxic products under pressure, through both these very permeable structures. I believe the ureter plays almost as great a role in this condition as the kidney pelvis itself. In all my cases of typical pyelitis the renal functional test, with phenolsul-

fonephthalein, gave little or no evidence of renal impairment, except in those of a fulminating type, those where the disease had been running for some time or those where pre-existing renal disease had destroyed kidney cells. The symptoms of the type 2 infections were not particularly different from the type 3, except in the history. They all gave a story of previous attacks of pain in the side, and many of hematuria, frequency and dysuria.

Diagnosis.—In the sub-acute, or chronic, cases, with little general disturbance, the diagnosis is only made by finding pus in the catheterized urines. Never make a diagnosis of pyuria—particularly in a woman—by the examination of a voided specimen. There is usually very little difficulty in recognizing the moderately severe type. The sudden attack of pain in the back, side and down the course of the ureter, accompanied by chills and temperature, with some frequency and burning at urination in a pregnant woman, is almost conclusive evidence of renal disturbance. Previous knowledge of pus or bacteria in the urine will be of assistance, but if absent at the first examination is not absolute certainty that a pyelitis does not exist.

The severe types are sometimes more difficult to diagnose than any other, and simulate acute intro-abdominal disease very closely. Appendicitis, acute adnexal disease and cholecystitis must be differentiated. This can usually be accomplished by a proper urologic examination. Appendicitis particularly, is frequently confused with acute, right renal infection, but in all pregnant women, where this condition is suspected, catheterization of the ureters should be performed, as a safeguard. An xray examination should be made on all pregnant women showing symptoms of renal infection, thus ruling out calculus.

The information as to whether the infection is only a pyelitis or has extended into the parenchyma of the kidney and becomes a pyelonephritis is obtained by performing a renal functional test, with thalein, after catheterizing the ureters. Patients where the disease is confined to the pelvis and ureter alone will show very little or no functional loss, but where a pyelonephritis is present, the percentage output of the dye through the catheter of the affected side will be much lessened. This is also true in type 2 of this disease, where conditions, as renal abscess, tumor, hydronephritis, etc., are present. The blood pressure and blood chemistry are not particu-

larly altered, and are of very little value.

Post-partum pyelitis is often caused by catheterization of the bladder for retention of urine. Emptying of the bladder after confinement should be done only under the most absolute of necessities and then should be carried out with most strict aseptic precautions. After catheterization it is well to leave about two ounces of saturated boric solution or one-half ounce of 5 per cent. argyrol in the bladder.

Treatment.—The treatment of renal infection in pregnancy depends entirely upon the type and severity of the disease. In type 1, with "cocci" infection of the cortex and possibly parenchyma of the kidney, immediate nephrectomy is the only indication, as these conditions have very little tendency to improve and the co-existing pregnancy has but slight influence upon their course; so that therapeutic abortion would be of no benefit. These cases should be treated as if pregnancy did not co-exist.

The procedure in type 2 would depend upon the evident severity of the disease. With high, continued temperature, the uterus should be emptied at once. Usually these conditions will then abate the excessive acute picture and can be nephrectomized at a later date without serious jeopardy to the patient. The removal of a kidney in the face of acute infection is always a dangerous procedure, and should only be approached when no other avenue of escape presents itself. If, on the other hand, the infection is not particularly acute and there seems to be no interference with drainage from the kidney, this type of case may be allowed to proceed, under constant supervision, or a nephrectomy may be considered if pregnancy is not too far advanced. Unfortunately, or sometimes fortunately, this type does not set up severe symptoms until late in pregnancy, when a nephrectomy is hardly justifiable. An induction of labor with premature birth may be the best solution of the problem. Each case must be decided on its own merits, and the particular procedure best fitted for the individual followed. In my own series I performed nephrectomy for a calculus pyonephrosis at the third month of pregnancy, because of severe pyuria, and advised therapeutic abortion on two others at seven and a half months, infected with hydronephrosis and pyonephrosis, respectively; doing nephrectomy at later dates.

The treatment of the ordinary, or colon bacillus, pyelitis is a graduated course, depending upon the individual case. The ma-

majority of infections are only mild, and rest in bed, with free catharsis, restricted diet, forced fluids, heat to the affected side and the internal administration of hexamethylenetetramine and sodium benzoate will suffice. The medical treatment consists in making the urine, as far as possible, an unhappy abiding place for bacilli and to wipe out the focus of their entrance into the urinary stream. As the large bowel is probably the organ primarily at fault every effort by diet, catharsis, colonic irrigation, etc., should be made to alter this condition. The reaction of the urine should be abruptly changed at times by diet and drug administration. Hexamethylenetetramine, with sodium benzoate or sodium acid phosphate should be given for a time, and the urine made strongly acid, then suddenly this is switched to alkalinity by the alkaline diuretics and large quantities of water.

If, however, the condition tends to chronicity, more strenuous efforts towards a cure must be enforced, or real damage to the kidney tissue itself will result. This happened in one of my cases. A fairly severe pyelitis was allowed to run six weeks, with only the usual treatment. Upon admission to the hospital, catheterization of the ureters and renal functional test showed an entire loss of urinary output on the right side, with an enormous number of pus cells. A therapeutic abortion was immediately advised, with a perfect recovery. The patient was advised to return to the hospital in two months if no symptoms intervened before that time. Upon readmission, a catheterization of the ureters and functional test showed no output and few pus cells. Nephrectomy showed an atrophic kidney, and microscopically, pyelonephritis.

If the initial symptoms of the attack are extremely severe and after forty-eight hours' of treatment no remission has taken place the patient should be cystoscoped and the ureters catheterized. This will obtain drainage for the infected urine and at the same time lavage of the renal pelvis carried out. Personally, I believe the effect of lavage, with boric acid or saline, obtains as good a result as the use of solution of silver nitrate in the early stages. Silver nitrate is very irritating to the mucous membrane of the renal pelvis and ureter, and I have observed severe reaction to follow its use. Actual cleansing and drainage are the principal objects gained by pelvic lavage. Ureteral catheterization is not without its irritating after effects, and one should be careful about injecting an addi-

tional irritating substance. The use of a 15 per cent. solution of argyrol is, in my opinion, of service and is much less irritating than silver nitrate. My disappointment in the therapeutic effect of mercurochrome upon the bladder and urethra has been a factor in making no use of it for pelvic lavage in acute pyelitis.

If the case is one of particular severity the catheter may be left in the ureter for drainage and frequent irrigation, as first advised by Albarran and later by Caulk¹⁰. The catheter is surprisingly well retained in some patients, though acting as a foreign body, it often sets up severe ureteral colic in others, and removal becomes necessary.

If, after several irrigations of the renal pelvis and ureter, there is no improvement in temperature, pain and general condition of the patient, what is the next step? The answer is only therapeutic abortion, though, if the disease continues long enough, most of these cases will abort themselves. This I have observed where patients absolutely refused interference with the pregnancy.

After emptying the uterus there is always remission of the renal condition after a few days, unless a renal pyogenic infection of the cortex or parenchyma has taken place.

The question may be well asked here: What about a subsequent pregnancy in a nephrectomized woman? Usually there is very little danger. Practically the only fear to be exercised is in cases where the kidney has been removed for tuberculosis or neoplasm. Paul Theodor¹¹ says that after four symptomless years this danger is over. I believe this to be true of neoplasm, but my own opinion in tuberculous urinary disease would be founded on the condition of the bladder, as shown cystoscopically, and the amount of frequency, particularly nocturnal frequency.

I have nephrectomized two young women for renal tuberculosis, who have later borne children, with no bad result. Matthews¹² culls 200 cases from the literature, with 215 labors and two deaths. Theodor reports thirty-one cases, with forty living children borne and fourteen abortions; many being unnecessary. Nine of these were in tuberculous women, who became pregnant twenty-one times, with twelve living children and nine abortions. When one bears in mind that the human kidney is many times too large for the bodily needs, the fear of pregnancy with one kidney is greatly lessened. If it is the left kidney that remains and no urinary symptoms are

present there should be no consideration of the condition at all.

I am reporting twenty-five cases here; all of the severe type and all hospital cases. Five of the cases were of the type 2 variety, with pre-existing renal disease. Three were very acutely sick and were aborted, with later nephrectomy. These were over thirty-five years of age and were multiparae. Two were not acutely sick—were in the early months of pregnancy and were nephrectomized at once. All recovered.

Of the type 3 cases, seventeen were in primiparae, and four in multiparae. In the primiparae the months of invasion were between the fifth and seventh. In the others, one had a pyelitis still present from a former pregnancy and went to term, the infection being practically cleared up by pelvic lavage, one showed first symptoms at eight months and went to term in good condition, and two were post-partum infections that cleared up after one treatment. One of these latter has also a well-marked tuberculous lesion in each lung. She was a para thirteen.

Of the primiparae all had high temperatures; one being admitted with 105.4 fahrenheit. Sixteen had the symptoms almost entirely on the right side, and two on the left. Ten had deeply congested bladders, as shown by the cystoscope; four had slight congestion on the floor; and four showed no sign of any inflammatory condition of the bladder or ureters at all. Four showed definite signs of obstruction at one or more points in the ureter. Fifteen showed unmistakable signs of retention in the ureter by a rapid, steady drip of turbid urine, as if under pressure. Three of these cases were aborted artificially, one was caesareanized, per vaginam, and one aborted herself. The others all cleared up under treatment.

All mothers in the entire series recovered.

Conclusions.—When a woman presents herself as a candidate for pregnancy she should have a proper xray examination of her teeth and urinary organs. The former to detect possible foci of pus and the latter for calculi. Chronic tonsillar disease should be looked after, as well as any pyogenic focus that may be known to exist. In the urine a trace of albumen should cause a suspicion of pus and a catheterized specimen at once examined microscopically. If pyuria exists, a careful urologic examination, with catheterization of the ureters, renal functional test, pyelogram, etc., should be made to determine pre-existing renal disease and define its curative procedure.

If, after pregnancy is established, pus begins to appear in the urine, a proper examination should be made to ascertain its source, and if it be only of the ordinary colon bacillus type, preventative measures by diet, catharsis, changes of posture and internal medication should be taken to erase it.

In the severe or fulminating types of infection the ureters should be catheterized at once, and the type of the disease determined. If a surgical kidney is present, nephrectomy or abortion must be determined upon, as best befits each individual case. If the examination determines it to be a pyelo nephritis a cure can usually be brought about by pelvic lavage, retention catheter drainage and eliminative procedures.

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THE EVALUATION OF SYMPTOMS AND SIGNS IN THE DIAGNOSIS OF PULMONARY TUBERCULOSIS.*

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The title of my brief talk tonight suggested itself to me when I was asked to

*Read before the Hudson County Medical Society, from the Tuberculosis service of Dr. Pollak at Jersey City Hospital.

take part in this symposium for several the question of early diagnosis needs no reasons. First, it is quite apparent that for the question of early diagnosis needs no emphasis, and, secondly, the experience of many actively engaged in seeing suspected cases for diagnosis are impressed with frequency with which non-tubercular patients are unjustly labelled with the diagnosis of tuberculosis to the detriment of patients, community and the doctor himself.

There was a time when those called upon more often to see cases of suspected tuberculosis, were more likely to commit themselves to the latter diagnosis: of late however with the benefits of further observation, experience has taught us greater caution and has established more securely a state of open mindedness, unbiased by suspicion. In his praiseworthy efforts toward early diagnosis, many medical men so-called lung specialists as well as general practitioners are too often found committing themselves to a positive diagnosis on insufficient evidence.

It is certainly not necessary any longer in most cities to stress early diagnosis, in fact I am afraid that this very idea ever in the medical mind warps his judgment and colors his vision, in many instances where he might do better had he the courage to take time to consider rationally the evidence at hand. The problem is changing and a Canadian (Stewart) writer recently said, "Ten years ago the burden of all papers on diagnosis was that it should be made early and ever earlier; now the burden is that diagnosis should be accurate and even more accurately."

Accuracy demands thoroughness in history and examination, assuming a consciousness of the more essential and the less their relative value. The diagnosis of pulmonary tuberculosis involves a broad knowledge of internal medicine, perhaps more so than any other specialty. Certainly much more than the ability to detect physical signs or read X-ray densities. What has been said of medicine may well be repeated for the diagnosis of pulmonary tuberculosis—"that this is an art which considers the constitution of the patient and has principles of action and reasons in each case."

Let us stop in our doubtful and borderline cases and ask ourselves have we con-

sidered everything, the "constitution of the patient" and are we warranted in our conclusions or have we been hasty, overlooked other possibilities and reasoned on meager or ambiguous premises. It is well to remember how experience is fallacious and judgment difficult. The problem before us then is accuracy in detecting the disease when the evidence is meager and also in correctly interpreting a situation replete with signs and symptoms. We meet this problem in the ambulant clinic or office patient more frequently of course but quite often at the bed side especially in the hospital. One can only refer to the high spots in this task this evening, and it is not my intention to go into details, but rather as I have already indicated to sound a warning against inaccuracy without wishing to detract in the least from the necessity of early diagnosis. It is admitted that under some circumstances and limitations an unwarranted diagnosis of tuberculosis is less culpable than failing to make it at all when it should have been.

In the cases with suspicious symptoms thorough examination is necessary and a familiarity with the normal and abnormal. Here I might digress to refer to the faulty methods of teaching physical diagnosis in vogue in the past and perhaps in the present. Didactic instruction to groups of students followed by their unchecked efforts to find the signs they were told to look for, leaves a large uncertainty in the medical students mind as to the actual nature of these signs. He enters the average hospital as an interne and rarely does he find an officer who does much to clarify the mental mist as to pulmonary diagnosis. He hears terms to often confusing as to significance and rarely correctly translated into pathology. This fact was clearly recognized by the Surgeon General in the recent war, so that under the able direction of Col. Bushnell a method of uniform instruction was developed whereby regardless of previous training or ability, every medical officer assigned to the tuberculosis division, was compelled to take the course of intensive individual instruction in the normal and pathological lung. This was done with the student officer blindfolded while listening through the same stethoscope to the signs demonstrated by the instructor. As you know any one can develop any type of breathing or adventitious signs on anybody, especially if the subject be

trained to do this for class. There was little doubt left in ones mind as to the reality of these physical signs after a demonstration of this kind and less margin of error when sought for in a systematic manner.

The indications are promising along these lines for the future. We have already a nucleus toward this ideal in our present City Hospital Tuberculosis Service. It is really surprising how promptly and how well our internes develop in their ability to go over the average chest and plot out the extent and type of lesion. However it must be admitted that there are cases that in spite of all yield little upon examination and remain undetermined for some time. It is in these cases that Xray findings under good technique—and this must be emphasized—are of great value. The value of the Xray lies in a good technique and a large experience in interpretation. This experience is the better if based on honest, clinical comparison and autopsy control. With this as a working basis the large group of patients with suspicious symptoms, the so called neurasthenias, hyperthyroid, and other endocrine dysfunctions, obscure fever, subacute bacterial endocarditis, focal infection, upper respiratory infection of nose, sinuses, throat, etc., will be differentiated much more often than otherwise. The time taken to do this need not interfere with the proper carrying out of the regimen that would be followed were the cases proven to be tubercular.

The other problem in evaluation confronts us in those cases with definite physical signs that require interpretation. (a) Cases with healed signs, or old healed infection must not be regarded in the same way as those with active disease. A difficult matter in some complicated cases (b) Too often a hasty diagnosis is made in cases with profuse but persistently negative sputum, that are bronchiectases, abscesses, etc. Here the location usually basal, and careful study of the Xray is helpful; also the preceding history. Some of these cases take a long time to clear up. (c) When the signs are bilateral largely bronchial, and especially out of proportion to the clinical picture, we must look for emphysema with chronic bronchitis, pneumonococcosis, cardiac deficiencies, etc. The same rules apply to the differentiation of these

and other forms of pulmonary pathology as were mentioned under the discussion of suspicious symptoms, excepting the fact that it becomes a matter of accuracy in determining lung pathology and all that this entails. We keep these cases under observation for physical signs. In conclusion, I would repeat that in justice to the patient and the physician, every effort and means available be utilized in all cases not positive, to evaluate as accurately as possible the suspicious symptoms and signs of tuberculosis before putting on record a diagnosis that means so much in the happiness and life of the individual.

CLIMATE IN THE TREATMENT OF TUBERCULOSIS

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To discuss fully, the subject of climate in the treatment of tuberculosis, would take up considerably more time than that given up for the subject this evening. I will therefore be as brief as possible and present that side of the subject with which I am personally most familiar. Climate in the treatment of tuberculosis may be classified broadly into two types. First, the sedative or relaxing type and second, the stimulating type. The sedative types are the ocean, island and coast types. The stimulating type is the median high or the high altitude type. Tuberculosis, complicated by chronic bronchitis, cardiac and renal diseases, and nervous instability, requires the sedative type of climate and should never be sent to any place with an altitude higher than 1,800 to 2,000 feet. Bone lesions in children do well especially in the coast type of climate. Tuberculosis not so complicated should by preference be sent to a stimulating climate to increase the vital resistance.

The high altitude climate is that above 3,000 feet and is usually dry. Because of the low humidity, changes in temperature are not readily felt. The days are warm and the nights cold. The air is clear, sunshine is prevalent, and there are a maximum number of hours during the year when outdoor living, so essential in treating tuberculosis, can be had with a minimum amount of discomfort. If there is anything in the short wave light therapy in tuberculosis, the sunlight in these al-

titudes has a greater percentage of these rays, than anywhere on earth, except possibly along the seacoast. The high altitude is stimulating. The rate and depths of breathing is increased. Our average was between eighteen and twenty. The pulse rate is about twenty beats higher than at the sea level. The blood pressure though it may drop at first, eventually reaches a level of from ten to twenty M. M. of mercury higher than at the sea coast, with a widening of the pulse pressure range. There is an increase in the number of red cells. The average counts we received on acclimatized patients was between 5,500,000 and 6,000,000 reds. There is also a proportionate increase in the white cells, especially the lymphocytes. Our average white cells counts were between 9,000 and 12,000, with about 50% of polymorphonuclear cells and 40% of lymphocytes. Eosnophyles were rare. At times count after count was made, without reporting any eosinophyles. Whether the increase in cells count is due to increased blood forming function of the bone marrow, or to an accumulation of cells at the periphery is a mooted question. The stimulus is no doubt given by the lowered oxygen tension. Lowering the atmospheric pressure, causes a change in the distribution of blood in the body. There is an accumulation of blood in the superficial vessels which have the least mechanical support, as in the lung.

The controversy as to the benefit of climate in the treatment of tuberculosis has been raging for years. Up to recently, there have been no statistics worth while, to compare with those issued from Eastern institutions. E. S. Bullock and F. T. Fahlen, reporting on the past twenty years experience at the New Mexico Cottage Sanatorium, compare their results on 1,454 cases, with those at Fort Bayard, N. M. and Trudeau, N. Y., in all including practically 13,000 cases. They show an increase of good results in the New Mexico institutions above those obtained at Trudeau, of about 10%. The estimate that we made from cases observed in Chicago and Denver, was between 10 and 15% better results in Denver institutions. Bullock's figures and our estimates come very close to agreeing. There is no doubt in my mind that certain cases do well in high alti-

tudes, that do badly in low ones. Cases with amazing lesions go on working and doing well, some having occasional breakdowns and some going on to complete arrest. These same type of cases when we tried to exercise them in Chicago, invariably broke down. There is a belief that tuberculous individuals arriving at an arrest in any climate, must make that climate their homes. That is not quite true. An arrested case should remain arrested in any climate.

Having shown the good phase of this subject, let us now discuss the problems which arise when we have the individual cases to think of. Before we can come to any decision as to whether we should advise the patient to break up his home and travel in search of health to some distant part of the world, there are several essential points of information, which we must have. The patient must be studied as to his physical condition, what type of complications might be present, his reaction environments, and his mental attitude. What is the economic status of the patient and his family, is there any possibility of having the patient take the treatment at home, under proper supervision? Knowing the patient's side thoroughly, we must now have some information about the resort to which we wish to send him. What accommodations are present for taking care of the sick, the food supply, the opportunity to obtain work when he is convalescing, the charity organizations present, in case he becomes financially embarrassed, what institutions can he be entered into when necessary? What are the chances of his receiving the best of medical attention, and supervision? The question of proper medical supervision is one of the highest importance to any tuberculous individual who has any activity whatsoever.

Merely telling a patient to go west and rough it, is not only a fallacy but a crime. We have seen many cases, who having received this type of advice, come to us after a few months of following it, practically moribund.

P. Loomis well said, "Each case is to be studied, not as one having a certain disease which is ordinarily benefited by such and such a climate, but as an individual with distinct temperament, inclination and personal, peculiar phases of the disease."

After all, climate, giving only about 10% better results, should be considered a luxury, for which the patient must have the price and proper mental makeup. If the patient can receive all the comforts that he has at home or that he can obtain close at home, and can afford to pay for the extra 10% chance of bettering his condition, by all means give him the benefit of the extra chance. What is the use of offering our patients the 10% increased chance, when the possibility of obtaining the main necessities are not at hand if we send him away from his responsible relatives, friends and community. What is the use of climate, if food cannot be obtained, where shelter and clothing are hard to get. Where the means of obtaining a livelihood, aside from the hardest kind of physical labor is practically unobtainable, and where supervision is not at hand. We know that the sheet anchors in our treatment are, food, air, rest and supervision, and I feel that supervision is of extreme importance. In handling a large tuberculosis problem, the local, county or state institutions, close by home, have the best chance of obtaining worth while results. To pay 100% to try to obtain the illusive 10% is indeed bad logic as well as bad economics.

PRESIDENT'S ADDRESS.

At the Annual Meeting of the
Middlesex County Medical Society.

By Charles W. Naulty, Jr., M. D.,
Perth Amboy, N. J.

At the annual meeting you conferred on me the honor of being the president of your Society for the ensuing year, and as part of the responsibilities of the office is the presentation of a paper by the incumbent, I will devote my talk to general conditions in the county rather than to any particular disease or locality.

Middlesex County has a diverse population, from the strictly rural to the most modern urban, with all its attendant evils, and at this time it is a strange commentary to make, but the outlying districts are more accessible by good roads than many places in our own city. The four sites of industrial activity, Perth and South Amboy, New Brunswick and Carteret, are widely separated and at present, except for Carteret, they are supplied with hospital facilities. The accidents and disabilities resulting from industry from the large part of our hospital ward work.

In Perth Amboy the population is practically entirely composed of the working class, and as recent surveys have shown, this class in the ultimate analysis receive the poorest kind of medical treatment, as they are not eligible or will not accept ward treatment and cannot afford unlimited investigation and consultation from the necessary specialists.

Specialistic development in the medical sciences has not progressed in the past as rapidly as noted in cities of the same type and size in the west, as we are in competition with the great medical center, New York, and in a lesser degree with Newark and Trenton. This situation is gradually righting itself, and the old ways of practice with a fountain pen, thermometer and prescription pad have practically disappeared, and today the hospitals at each end of the county are prepared to furnish the necessary laboratory and specialistic diagnostic aids so essential to modern treatment.

During the past thirty years the standards of medical education have been raised, and today a license to practice medicine in this State can be obtained only after fulfilling rigorous requirements. This elevation of our profession with the shutting out of the ill-trained graduate of the fly-by-night mercenary medical school has brought in its wake the attendant evils—osteopathy and the "chiro." We have fooled ourselves and made fun of these cults, but they are a constant menace, well fortified financially and assisted by able and adroit advertising, and the scanning of the bills introduced in the present session of the Legislature show what we must expect of this fry. Human nature is the same today with Coueism, as it was with Perkins' Tractors in the dim past, and in the eyes of the public it is a terrific indictment of our profession, when a shoe clerk or a letter carrier can, by a manipulation of our cervical vertebrae, cure anything from general paresis to placenta previa. The State Society Committee on Welfare has been very active, and to them we owe a debt of gratitude for the constant warfare they have carried on in the interests of the public health. The venereal and tuberculosis problem has been prominent before us. The care of the indignant or vagrant venereal case has not proven very satisfactory in this county, and I am not able to tell at this time whether this failure is due to lack of co-operation of the medical profession or to general dissatisfaction on the part of the public to the general scheme, or whether it is to a combination of both.

The tuberculosis question is being actively handled, and we all know the agitation that has been on foot in this county for the erection of a county sanitarium, and that the board of freeholders only recently held a hearing at the county seat. It is hoped in the interest of the public health that the county finances will at some time in the near future be in such shape that the county sanitarium project can be accomplished.

At the annual meeting in December, the State President spoke of the desirability of interesting our women folks more in the work of our Society and suggested the appointment of a committee on this line. I would request authorization from the county society to appoint such a committee to show our complete willingness to fully co-operate with the President.

There is one other thing that should be considered with great attention. It is something that is greatly to the front in some of our fellow societies. It is a matter that is fraught with danger to all of us, something that is feared and dreaded by every practitioner, namely, blackmailing malpractice suits. It is the experience in many cases that such suits would die aborning if it were not for the unscrupulous methods and the assistance given by some of our professional colleagues. In this month's number of the Journal of the State Society the proposition has been made "that any physician who shall give evidence against another in a case of this character, save as to matters of fact, when under subpoena, shall be liable to a charge of unprofessional conduct."

This brings before us another subject that has been glossed over in the past, ethical conduct of our members. We are all familiar with the type of hyperethical colleague who is almost humpbacked in front from the extreme efforts he makes to straightly walk the narrow path of righteousness. On the other hand, who are there of us who have not been unethical by silence, by implication and by failure to say a good word for another colleague, whom we have succeeded in the care of a case? There are all grades of unethicity, from the every-day, good-natured, lovable cuss, who very theatrically pours his predecessor's medicine into the sink and then immediately writes for the same ingredients in another colored vehicle, on down the line of infamy and degradation to the narcotic dispenser, the bootlegger and the murdering licensed abortionist. The Federal gov-

ernment, through its machinery, is attending to the dope peddler, and in time will no doubt reach the medical bootlegger. The medical abortionist is always a canker spot in our profession. It requires radical action for its extermination, but with the protecting veil of legal subtleties, it seems that nothing short of a catastrophe can furnish the moral force necessary to strip him of his power and expose him to the avenging shafts of an outraged public decency.

It has been suggested in one of our neighboring societies that a committee on ethics be established. This body to hear the details of such cases as arise or that are brought to its attention, functioning along lines similar to the grievance committee of the bar associations. I mention this for your consideration and hope that it will provide a topic for discussion.

In point of numbers our Society is small, but I feel sure that during the coming year we can count upon your loyal support.

In passing, I have the sad duty to announce the death of our brother, Dr. C. M. Slack, who, I understand, was the oldest member of the State Society. The toga of seniority has descended to the shoulders of another of our members, our esteemed Treasurer, Dr. English, who now becomes the oldest member of the State Society.

During the holiday season it was necessary to remind several members of their delinquency in dues; as our Treasurer is untiring in his pursuit of such offending colleagues, and no further mention has been made by him, I take it that we are again over the top with a 100 per cent. paid-up membership.

The spirit of progress shown by the Board of Governors of the Perth Amboy City Hospital in the erection of this beautiful auditorium, designed with a view to our medical society meetings, should be strongly commended, and I think it would be proper for us to officially acknowledge our sentiments of appreciation for the splendid facilities they have placed at our disposal.

Since the change in our bylaws to hold quarterly instead of monthly meetings, it becomes more necessary than ever that we have a full attendance at our meetings. The Committee on Programs will endeavor to see that our other meetings are of an instructive and interesting nature, and that they will fully repay us for our visit to the meeting.

In conclusion, I bespeak your earnest assistance and co-operation in the work in our Society during the coming year.

ADDRESSES AT THE
ACADEMY OF MEDICINE OF
NORTHERN NEW JERSEY, NEWARK
At the Annual Meeting and Dedication
of the New Auditorium.

Address of Dr. Edward J. Ill.

The duty and pleasure has been assigned to me to welcome you here tonight. I suppose the honor came to me, because I helped launch the ship, as its first president. We are gathered to celebrate the opening of our auditorium. It is with justifiable pride that we point to the achievements of this academy.

A little over twelve years ago, a few enthusiastic doctors gathered with the object of bringing into being this new society. They soon had the whole profession of this section behind them. Its democratic spirit was to be a dominant figure. Every one was invited to come. Every one was asked his opinion, his experience and his help. We invited other scientific bodies, who were seeking to allviate human suffering. Their help was enthusiastically welcomed. There were to be no classes. The humblest was as well received as the hautiest. Our efforts were to elevate the standing of the profession. We were to gather and listen to the progress of our art and science. The object was to increase our knowledge to the end of helping the suffering.

We have had in mind that an institution such as this would enhance our usefulness and increase the respect which the people in general ought to have for the healing profession. And lastly, it was to give those, who had the ambition to excel in knowledge and attainments, a chance to show what sort of metal they were made of.

While we thankfully received 'donations from the laity, we made no special efforts in this direction, but rather looked to the liberal hand of our own profession to defray the expense of this splendid institution. The fullfilment of our expectations in this regard was realized.

For five years we met in the small quarters of the Wiss Building, then removed to the less acceptable auditorium of the Board of Health. We soon realized that we had to have our own home, if there was to be real progress. We realized that the lodging house was one thing and the home another. Three years ago we came here. Thanks to the energy, enthusiasm and scientific spirit of the late Dr. Disbrow, we soon had as fine a home as any body of medical men could desire. Our

scientific meetings were so well attended that increased accommodations became an absolute necessity. The result of our endeavors was this spacious hall, which you have done us the honor to assist in dedicating.

We most cordially welcome and thank our esteemed and distinguished conferees from other States, who have come to assist us and encourage us in our efforts.

We know that the Fellows will ever be interested in the work, and that the coming generations of doctors will think well of us for this beginning. To our guests I wish to say if you like our company and efforts come again. You will ever be welcome.

Address by Dr. James Hunter, Jr.

President of the Medical Society of New Jersey.

The Medical Society of New Jersey was organized in 1766, received its first charter June 2, 1790; the act under which this charter was granted automatically expired in 1815. The following year, 1816, a new act provided for a district society in each county, and it was during this year that the State Society at its annual meeting constituted the district societies in the counties of Middlesex, Somerset, Essex and Morris. Ninety-five years after Essex County Society was instituted, that is to say in 1911, this academy came into existence, its membership so largely made up of members of the Essex Society that it can be looked upon as the legitimate progeny of the old Essex County Society. The chief of Essex County Society, the grandchild of the Medical Society of New Jersey.

The pride of parentage in lusty offspring is natural, but when, in addition to physical vigor, is added mental and intellectual equipment of the first order, operative skill, the spirit of research, constantly in evidence, and a moral character above ethical reproach, do you wonder that parental pride reaches its limit, and that the State Society is a proud progenitor.

"What makes a hard world?" some one asked, and a newspaper wit answers: "Too many of us are generous with our brickbats and stingy with our bouquets," or to put the thought in another way, a friend of mine once said: "There is no fun in a graveyard, give me my bouquets now." I come to you tonight in that spirit. I bring you in the name of the State Society congratulations and greetings for this happy occasion, I want you to know and feel the

side and admiration in which you are held by the State Society, and knowing this, that it may act as an incentive to still greater things in the future.

The fine character of your membership, the high aspirations and untiring devotion of your officers, past and present, to those professional ideals that lead ever upward and onward, the progressive spirit ever present in your stated and sectional meetings, the list of distinguished surgeons, who have been your speakers, teachers and guests, bespeak an organization of which the State Society is justly proud, and from which she looks for greater things, as the years roll on, and her best wish for you tonight is that you may continue to deserve commendation, and like Merlin, you may

"Follow the Gleam
Down to the haven,
Call your companions,
Launch your vessel
And crowd your canvas,
And, ere it vanishes
Over the margin,
After it, follow it,
Follow the Gleam."

Address by Dr. G. E. de Schweinitz.

President of the American Medical Association.

Mr. President and Members of the Academy of Medicine of Northern New Jersey, Ladies and Gentlemen:

With real pleasure I have accepted the highly appreciated invitation to be present on this occasion and in a few words convey to you, officers and members of the Academy of Medicine of Northern New Jersey the congratulations of the American Medical Association, those of the oldest medical school in this country. The University of Pennsylvania, those of the oldest Medical Society analogous to your own in continuous existences in this land, the College of Physicians of Philadelphia, and those of my own, as a worker in the ranks of the great profession to which all of us have the honor to belong.

Your Academy is young in years, but has given fine example of the will to achieve. The period of your existence since the incorporation of this Academy has been rich in productive effort. Your brave and generous plans, notably supported, are consummated this evening in the dedication of this handsome building. Your library and museum take high rank in the medical equipment of this country.

On all these matters, on all of these achievements, you are greatly to be felicitated, and I am proud to join in the chorus of congratulations, and today my voice to those which shall make these walls ring acclaim.

The impress which your physicians have made on the history, the medical life and the public achievements of this State is a notable one. Of those who have recently left us, none is so greatly missed as that man whose deep interest in this Academy has placed it, and, in a larger sense, the physicians of this State, deeply in his debt as the happy beneficiaries of his liberality. We, your guests, crave permission to join with you, physicians of this State and members of this Institution, in cherishing the memory of Dr. William Disbrow.

Should we for a moment recur to early days, we may think of William Burnet, a surgeon of fame in the period of the Revolution, and among the founders, if not the founder, of the first State Medical Society in this union; of John Cochran, who, although a native of Pennsylvania, practiced in Burlington, and became on Washington's nomination the surgeon-general of the Army of the Middle Department, and later was promoted to be the director general when Shippen resigned that office; of Thomas Henderson, physician and publicist, the "solitary horseman," who gave Washington first information of the tragic failure of a military plan; of Jonathan Elmer, declared by Benjamin Rush to be exceeded by no other physician of his time in medical erudition; of Lewis Condict, a physician of note, first president of his county society for years a member of the Assembly, an example of one who in spite of the exactions of private practice, found time to serve faithfully the public interests; of James Craig and his remarkably successful record in obstetrical practice during a period when only too often the birth chamber became the death chamber; of Henry L. Coit, a pediatrician of distinction whose praiseworthy efforts to secure pure milk—certified milk, as he called it—constitutes a notable achievement; of Emma Ward Edwards, the pioneer woman physician of this State; of Thomas Dunn English, who although Pennsylvania-born and there medically educated, received his early instruction in the Friends' Academy in Burlington, and spent his closing days in this

city, author of the immortal verses, "Don't You Remember Sweet Alice Ben Bolt"—a song which for years thrilled one audience after another, and brought the hearers, cheering, to their feet; of Stephen Wicks, the great authority on the medical annals of this State, whose History of Medicine in New Jersey is a notable contribution to the records of our profession; of Charles J. Kipp, an alien by birth; but becoming a figure of distinction in the chosen branch of his profession; I cannot forbear to sound a personal note of sincere affection and gratitude—he steadied my feet when they timidly trod the paths of early endeavor.

These are only a few examples—the list is a long one. Surely it is not without dignity in the background of medical effort in this State, nor with any lack of inspiring exemplars in the order of men set apart for the sacred office of the physician, that the Academy of Medicine of Northern New Jersey has come into existence.

Surely again we recognize that our professional life is more than meat, our effort more than raiment. If we fail to recognize the beckoning obligations which surrounds us, fail to embrace opportunities, then organized medicine fails its part to wield an influence which it was destined to create, and which it is our duty to maintain. And ranking high among these obligations and these opportunities is our community duty. The time has passed when a medical school is alone concerned with the isolated task of instructing students within its walls; a hospital only, with patients within its wards; a practitioner solely with effort to enhance his individual prestige, a medical society, or an Academy like this one, merely with scientific discussion within its halls. On school, hospital, physician, medical society and medical academy larger demands are being made; stretches before them wide fields of community service.

Such service the physicians of the State of New Jersey have given in the past, such service they are rendering in the present and shall in the future; such obligations the Academy, true to its traditions, will meet, and hold high the torch which lights the road to the larger medical life.

In his inaugural address, the first president of the College of Physicians of Philadelphia, 136 years ago, prayed that

wisdom, prudence, discretion and judgment would be granted unto its Fellow to good effect and useful purposes, and prayed further that those who heard him and those who were to follow in their footsteps, would publicly and privately serve their generation. In this prayer know all the members of the Academy will join, and may great success attend your endeavors.*

(For the Dedicatory Address by Prof. J. T. Finney, which followed the above address see page 145, et seq.—Editor.)

County Medical Societies' Report

BERGEN COUNTY

Frederick S. Hallett, M. D., Reporter.

The regular monthly meeting of the Bergen County Medical Society was held at the Union League Club, Hackensack, April 10, 8:30 p. m. Dr. Conrad, president, occupied the chair; twenty-six members being present. Dr. Wells P. Eagleton, of Newark, was to have been the speaker, but owing to illness was unable to be present.

Dr. J. Finley Bell brought up for discussion the problems of social service and welfare work and the relations of such work to the public and the medical profession. A resolution was passed, calling a special meeting April 10, to further consider the subject. Dr. Haven Emerson and Dr. Julius Levy are expected to be present.

Special Meeting.

At a special meeting of the Bergen County Medical Society, held in the Union League Club, Hackensack, April 19, a resolution concerning social service activities in the county was passed.

The resolution provides for the appointment of a committee composed of representatives, medical and lay, from the hospitals and also from the various social service organizations now operating in the county, for the purpose of building organizations in connection with each of the hospitals, to be known as "Social Service Activities," under the control of the hospitals. They are to be medically directed and controlled.

Dr. J. Finley Bell, of Englewood; Dr. Haven Emerson, of Columbia University, and Dr. Julius Levy, of the State Department of Health, were the speakers. Dr. Emerson discussed the nursing organization from many viewpoints, and Dr. Levy, consulting chief of child hygiene for the State board, told of the activities he knew in connection with the State board.

Dr. Frederick S. Hallett, of Hackensack, presided.

The committee called for in the resolution will be appointed by Dr. E. K. Conrad, president of the society, and will report at a future meeting.

BURLINGTON COUNTY.

Daniel F. Remer, M. D., Reporter.

The regular meeting of the Burlington County Medical Society was held at "Fair

ew," the Burlington County Sanatorium for tuberculosis, at New Lisbon, on Wednesday, April 11, 1923, Dr. Harry L. Rogers presiding. Dr. M. W. Newcomb, chairman of Section on Practice of Medicine, had arranged the following program:

"The Effect of Pregnancy on Tuberculosis," Dr. B. S. Pollak, medical director of Hudson County Tuberculosis Sanatorium, Secaucus.

"Diagnosis of Early Pulmonary Disease," Dr. S. B. English, superintendent of State Sanatorium for Tuberculosis, Glen Gardner.

Both papers were freely discussed. Dr. Charles B. Noble, of Philadelphia, an honorary member of the society, was present and entered into the discussion.

The Board of Chosen Freeholders had invited the society to dinner, as their guests, and an excellent dinner was served. The society adjourned to meet in Moorestown in June.

CUMBERLAND COUNTY

Elton S. Corson, M. D., Reporter.

The Cumberland County Medical Society was hospitably entertained at Ivy Hall, the sanatorium of Dr. Reba Lloyd. A goodly number of delegates from neighboring county societies were present. Dr. Walt P. Conway, district counselor, motored from Atlantic City and counseled the society, as to the transaction of the State Council. The State Medical Society will meet at the Chalfonte, Atlantic City, June 21-23. Reservations should be made at once, as the accommodations are fast being engaged.

Dr. Warren B. Davis, of Jefferson Medical College, was the chief speaker. Dr. Davis specializes in the correction of facial deformities. He had an extensive experience during the World War. He spoke on the correction of hair-lip and cleft palate deformities. He used the stereopticon with good success in showing the embryonic formation of the child; as to how the plates forming the lips, nose and palate failed to close together and caused such hideous deformities. No time of life is too late to have them corrected. The earlier the less likelihood of increased scars. As soon as the child shows that it is being properly nourished by gaining in weight, the operation should be performed. Flaps of skin are taken from the cheeks in some cases, in others the bone of hard plate is cut away from along the gums and stitched together at the center, while the space is allowed to granulate together. To restore the nose a piece of cartilage is removed from the rib and transplanted to form the septum of the nose and flaps are twisted around from the cheeks to cover the open space.

In many cases the mental condition of the patient is radically changed from one shunning society and the public gaze to a normal condition. The cosmetic effect is marvelous, while the parts functionate naturally. For the sake of the child's future welfare no parent should hesitate to have the child operated on, as indicated. There are persons whose prejudice or religious belief hinder them from having any deformities appearing at birth changed.

A well enjoyed supper of fried chicken, waffles and their accompaniments was served

in the cheery dining room of the sanatorium. The next place of meeting will be at the sanatorium of Dr. Madeline Hallowell, Atlantic City.

GLOUCESTER COUNTY.

H. B. Diverty, M.D., Reporter.

Testimonial Dinner to Dr. Hunter.

A testimonia dinner was tendered to Dr. James Hunter, Jr., of Westville, at the Woodbury Country Club, by the Gloucester County Medical Society, in honor of the fact that Dr. Hunter, a member of the county society, is president of the New Jersey State Medical Society.

Dr. H. B. Diverty and Dr. Duncan Campbell were the committee on arrangements and they saw to it that nothing was omitted that could add to a delightful occasion. An orchestra, consisting of three lady artists from a Philadelphia musical organization, delighted the assembly with a number of selections of high order, these being rendered during the dinner and also intermingled the addresses.

The toastmaster of the evening was Dr. Diverty, and he conducted that post of honor in his usual characteristic manner. The assembly drank a silent toast in memory of the late Dr. Harry A. Stout.

Letters were received from Drs. E. J. Marsh, Paterson; Wells P. Eagleton, Newark; William J. Chandler, South Orange; Archibald Mercer, Newark, all officers of the State Medical Society, and Dr. Walt P. Conaway, Atlantic City, counsellor for this district, and Dr. J. Harris Underwood, Woodbury, regretting their inability to attend. A letter was received from Dr. Work, secretary of the interior, or President Harding's cabinet, thanking the society for their kind invitation, but regretting that he was unable to be present, as he was required in Washington for an important meeting.

Dr. Diverty presented Dr. Alexander McAllister, of Camden, second vice-president of the New Jersey Medical Society, who prefaced his address with congratulatory remarks to Dr. Hunter. He said:

"In Dr. Hunter we have, I am sure, a physician who, like St. Paul, would 'prove all things, and hold fast that which is good.' I fear that we need more of his type, the type of men and physicians who break the bonds of useless tradition."

Impromptu addresses were made by Drs. Gilbert J. Palen, of Woodbury; Madeline Hollowell, of Atlantic City, and D. C. English, of New Brunswick.

Dr. Palen's address was humorous throughout and he would not allow the smile to "come off" the faces of his listeners, as humorous story after story was told, and as the laughter would die down to a ripple upon their faces he would convulse them with another from what appeared to be an inexhaustible supply.

Dr. English referred to Dr. Hunter's devotion to the welfare of the State Society and the profession generally since his election as president, in visiting and addressing the county societies, other State societies, the Academy of Medicine in Newark and other organizations, and his helpful interest in arrangements made for the coming annual

meeting of our State Society, which will doubtless be one of the largest and best meetings our Society has ever held.

ADDRESS OF PRESIDENT HUNTER

I am reminded tonight of those lines in Longfellow's courtship of Miles Standish—

"For there are moments in life, when the heart is so full of emotion,

That if by chance it be shaken, or into its depths like a pebble,

Drops some careless word, it overflows, and its secrets

Split on the ground like water, can never be gathered together."

"Let us then, be what we are, and speak what we think, and in all things

Keep ourselves loyal to truth, and the sacred profession of friendship."

I am deeply stirred and touched by this evening's evidence of loyalty and friendship upon the part of my friends who are members of old Gloucester County Medical Society, who together with the guests from other places have taken this occasion to set forth in tangible form their esteem and friendship.

There are no friends like our old friends, God bless them, and what is there in life that compares to the loyalty, sincerity, and fidelity of those who love us in spite of our many, many faults.

Someone asked a Kentucky belle for her definition of a friend, and she replied, "A friend is someone who, knowing all your faults and sins, can still love you." And so I feel tonight, and I realize and sense the deeper meaning of Whittier's lines—

"Sweet the offerings seemed, and yet

With their sweetness came regret

And a sense of unpaid debt."

It is to the loyalty of all my friends of the Gloucester County Society, especially the fidelity and love of my dear friend the late Dr. L. M. Halsey of this society, whose power and influence, together with those members of other societies of the state, who stood with us in the nominating committee in 1920, that I owe the honor of being president of the State Society, this evening.

I would not be human if I did not appreciate such loyalty and friendship, and my one hope is that I may do nothing in the conduct of the office, that will forfeit the esteem and respect of the friends who stand sponsor for me at this time.

Gloucester County Society has given to the State Society five of its Presidents:—The first, Dr. James Stratton of Swedesboro, one of the charter member of the State Society, was made its President in 1788. The second, Dr. Joseph Fithian of this society was chosen President of the State Society in 1849. In 1859, ten years later, Dr. John R. Sickler was elected President of the State Society. Forty years later, 1899, Dr. L. M. Halsey was elected President. Dr. Halsey served many years upon its most important committees, and having in a large degree the political instinct or genius, he was ever a potent force for the best interests of the society and the profession.

We owe our present active organization to the energy shown by Dr. Halsey and our present esteemed secretary Dr. George Evans Reading, in reviving an almost moribund society in

1893. The society at that time, 1890 to 189 was in a fair way to an early demise through lack of proper organizing stimulus, and the effective political sagacity of these two men what saved the day and reputation of old Gloucester County Society.

Our dear friend, the late Dr. H. A. Stout was another of the old Gloucester County fold who gave of his best for years to the State Society as its Corresponding Secretary. Stout was always a valuable member of the State Board of Medical Examiners, and when I was asked to appoint his successor, and upon taking counsel with those best fitted to judge of the type of man required, a man with political sagacity and a back bone, to conserve the best interest of the profession of the State, I turned instantly to our Secretary, knowing his fighting ability and fidelity to the higher things of the medical profession of this State, and asked him to accept the appointment for the best interests of the profession. This he did at once, and has given a good account of himself already in the work of this most important board.

Then there are my friends Drs. Diverty and Campbell as a committee in cooperation with the entire membership of this society and its guests to whose good work this pleasant evening's entertainment is so largely due.

Do you wonder then that tonight, while this function primarily is in honor of the office of President of the State Society, and while I may be justified in feeling a pardonable pride that as a member of the old Gloucester County Society I should be permitted to serve the State Society as its President, my strongest reaction at this moment is in response to the loving loyal friendship of all the members of the old Gloucester County Society, and their friends who have made such an honor possible.

And when that time comes, which must inevitably come to each of us, when we shall await the "Sound of the muffled oar," may Whittier's hope be mine:—

"Suffice it if, my good and ill unreckoned,

And both forgiven through thy abounding grace—

I find myself by hands familiar beckoned—
Unto my fitting place."

HUDSON COUNTY.

William Freile, M. D., F. A. C. S., Reporter.

The regular meeting of the Hudson County Medical Society was held on April 3 at the Jersey City Hospital at 9 p. m., Dr. Donohue president, in chair.

Resolutions on death of Dr. Faison were presented by committee, and a motion made that they be drawn up in suitable form and presented to Mrs. Faison; second and carried.

Legislative Committee reported that Assembly Bill No. 225 had passed and had been signed by Governor Silzer. There will be a fuller report of this at the next meeting.

Dr. Eckes, of Jersey City, was elected a member.

A permanent memorial to Dr. Faison was discussed at length, and finally motion made by Dr. Rector that a committee of five to ten be appointed to formulate some plan. This was seconded and carried.

Papers of the evening: 1. Dr. Patterson substituted for Dr. Wightman and read a paper

on "Functional and Organic Diseases of the Heart," which was discussed by Drs. Levin, Curtis, Rector, Miner, Steadman and McGrover. 2. Dr. Edward Hunt, of New York, spoke on "The More Common Neurological Conditions Met by the General Practitioner," which was illustrated by lantern slides. This was discussed at length by Dr. Shapiro, of Bayonne.

(We have from this society, awaiting publication, a paper by Dr. John F. Erdmann, on "Cancers of the Breast." Also one by Dr. Warren Coleman, entitled "Flora of the Intestines." At the first opportunity, when space permits, these papers, either in complete or abridged form, will be presented in one of our issues).

PASSAIC COUNTY MEDICAL SOCIETY

Leon E. DeYoe, M. D., Secretary.

The April meeting of the society was held in the Chamber of Commerce rooms on Thursday, the 12th, at 8:45 p. m. Dr. Thomas Wingman presided in the absence of the president. There were thirty-six members present.

A vote of thanks was extended to the Chamber of Commerce for the use of their rooms for our meetings, and it was regularly moved, seconded and carried that this society take out corporation membership in the Chamber of Commerce.

Appropriate resolutions, relative to the death of our member, Dr. James Crooks, were adopted.

Dr. J. C. McCoy brought out the fact that the young medical men of the county, who had not been in practice for at least one year and who could not therefore be members of the county society, were unable to avail themselves of our insurance privileges, under the State Society's contract. He thought that these men particularly needed protection of this sort. He introduced a motion that the secretary communicate with the insurance company to see if some provision could be made for these men. Motion was carried.

The paper of the evening was read by Dr. J. Roemer, the subject being "Principles of Deep X-ray Therapy." As this paper will perhaps appear in a subsequent number of the Journal it will not be reviewed at this time.

UNION COUNTY

Russell A. Shirreffs, M. D., Reporter.

The regular meeting of the Union County Medical Society was held in Elizabeth, on the evening of April 11th, and was attended by about fifty members. Drs. Holzman, Glazer and Holland were elected to membership. Dr. Charles H. Schlichter was appointed censor, to fill the vacancy caused by the recent death of Dr. E. B. Grier. Dr. H. R. Livengood was made a permanent delegate to the State Society and Dr. P. DuB. Bunting was selected as a member of the Milk Commission. Dr. Arthur R. Casilli, successor to the late Dr. J. H. P. Conover as the city pathologist, read an interesting paper on "Nephritis," which evoked a helpful general discussion. The program was concluded by refreshments and a social session.

Local Societies' Reports

BAYONNE MEDICAL SOCIETY

M. I. Marshak, M. D., Reporter

The Bayonne Medical Society met at the Elks' Club on December 18, 1922, Dr. W. L. Williamson presiding.

Dr. M. Shapiro reported a case of dislocation of the fifth and sixth cervical vertebrae. Interference in this case produced a complete paralysis.

Dr. M. Frank reported a case of secondary carcinoma of the spinal cord in the lower dorsal region, following carcinoma of the stomach. The main symptoms present are pain in the back, for the last three months, and weakness. During the past week paralysis of both legs has developed associated with difficulty in urinating. The liver and spleen are both enlarged. Dr. S. Woodruff stated that he operated on the patient mentioned by Dr. Frank, about ten years ago. The lower third of the stomach was a large hard nodular mass. He did a gastroenterostomy, which relieved the symptoms. He felt that the case was one of carcinoma of the stomach at the time.

Dr. C. J. Larkey wanted to know if any of the members had seen any typhoid during the past few months. He said he had had three cases during the past three months. The histories in these cases seemed to indicate that the disease was contracted in Bayonne.

Dr. T. S. Brady read the paper of the evening entitled, "Roentgenology in the Interpretation of Diseases of the Gastrointestinal Canal." It was a splendid and thorough presentation of the subject, given under the following heads: 1, Roentgenology, an important adjunct to clinical medicine; 2, Fluoroscopy; 3, Preparation of the patient; 4, Examination of the patient; 5, Fluoroscopy of the esophagus, its anatomy, physiology and pathology; 6, Types, function and fluoroscopy of the stomach; 7, Roentgenological divisions of the stomach; 8, Morphology of the stomach; 9, The appendix; 10, Stases; and 11, Differential diagnosis.

Dr. H. Axford in discussing the paper, reviewed the history of x-ray diagnosis of the gastro-intestinal tract, from the time of Lane and Jordon's original work. He stated that the examination is an aid to diagnosis not always positive. A clinical history is absolutely necessary. He bases his x-ray diagnosis a good deal on the history. He cited a case with persisting vomiting, in which the barium meal had not reached the normal position at the end of six hours. The jejunum was filled, the ileum was half filled and the stomach was empty. In two hours he found the meal in the same position. There was a history of laparotomy some years before. He made a diagnosis of adhesion, which was confirmed at operation.

Dr. Kresch stated that practitioners are apt to lay too much stress on x-ray diagnosis. He felt that the clinical history was of most importance. The x-ray is an aid. Only ten per cent. of cases with gastro-enteric symptoms have definite lesions. Barium is the opaque medium most frequently used with malted milk as menstruum. Dr. Marshak gave a review of the work done in attempting to obtain definite x-ray signs in tuberculosis of the intestinal tract. Dr. Woodruff stated that ten

DON'T FAIL TO ATTEND COUNTY SOCIETY MEETINGS.

years ago we were all enthusiastic about the use of the xray in diagnosis. The pendulum has now swung to the opposite side. He felt that the xray should be considered as an aid in diagnosis and should not be neglected. Dr. Sexsmith thinks that the xray has given us decided aid in the differential diagnosis of diseases of the appendix.

SUMMIT MEDICAL SOCIETY

William J. Lamson, M. D., Secretary.

The regular monthly meeting of the Summit Medical Society was held at the Canoe Brook Country Club of Friday, April 27, at 8:30 p. m., the president, Dr. Moister, in the chair, and Dr. Kay entertaining.

Present—Drs. Baker, Bensely, Bowles, Clark, Embury, English, James, Kay, Keeney, Krauss, Lamson, Meeker, Meigh, Moister, Morris, Prout, Reiter, Smalley, Tator, Tidaback and Wolfe.

Dr. Bert A. Praeger, of Chatham, was elected to membership in the society.

The library committee had no further report to make at this time.

Dr. Roger H. Dennett, of the Post-Graduate Hospital, New York city, gave a very interesting address on "Some of the Commoner Phases of Pediatrics," taking up Rickets, tonsils and adenoids and enlarged thymus. He emphasize the prevalence of mild cases of Rickets, due to low calcium and phosphorus content in the blood, and the very successful results obtained from the use of cod liver oil and sunshine. Unless urgent, he does not remove the tonsils and adenoids until three years of age. Indications for operation are obstruction, due to hypertrophy, repeated attacks of tonsillitis or otitis, adenitis, chronic cough, cyclic vomiting, some cases of malnutrition and diseases caused by focal infections. Cases of thymus enlargement may be recognized by abnormal breathing, chronic cough, asthma and undergrowth, and yield satisfactorily to the xray. The address touched upon so many points of interest that the discussion was general and helpful.

MORRIS PLAINS NEED MET, BUT LARGER DUTY FAILS.

Because the need of relief from congestion and its attendant dangers at the State Hospital at Morris Plains is imperative, Governor Silzer should sign House 317, which promises that relief. In amending the bill to limit its benefits to Morris Plains Hospital, however, the Senate failed in its larger duty.

The bigger question is the question whether New Jersey shall accept responsibility for her state care institutions and take the necessary steps to overtake her years of neglect of that duty, by providing the means of meeting it. House 317, as finally passed by the Senate and agreed by the House, leaves the larger duty still undone. The House is not to be blamed. It passed the bill originally, providing for the state-care problem as a whole. When the Senate, on the brink of adjournment so far as enactment of original legislation was concerned, cut everything out of the measure except Morris Plains, the House could do nothing but concur, if any relief was to be given, anywhere this year.

The Senate's action, however, was peculiar.

Senator Simpson of Hudson sought to amend the bill, restricting the benefits to Morris Plains Hospital and the term of the special half-mill tax provided to one year. On a viva voce vote the amendment apparently was rejected. Simpson's call for a poll of the vote however, developed a majority of four sustaining the amendment. Did Senators who were willing that the bill be passed as it stood insuring the performance of the state's duty to its helpless wards as a whole, get cold feet when it became necessary to register their votes clearly if that purpose was to be broadly achieved? It would seem so. However that may be, the primary responsibility for continued failure to meet their problem on a broad basis and solve it as it should be solved, belongs with Simpson and with Hudson County. Hudson's interest in Morris Plains is no greater than the interest of other North Jersey counties, her interest in the state's duty as a whole no less than theirs.

Those who stood with Simpson on the roll call that defeated the performance of that duty, save in restricted form, share his responsibility for whatever may be the consequence. The half-mill tax for one year will produce something over \$2,000,000. If the amendments were carefully drawn, and do what they were intended to do, that means \$2,000,000 or more for Morris Plains Hospital. That money can be put to good purpose there, and nowhere in the state is such a sum more urgently needed, in the interest of sheer human mercy to the helpless. But was it not an argument against this bill, in Trenton, that its real purpose was to benefit Morris Plains Hospital, North Jersey's refuge for the mentally unfortunate? Having amended the bill to make it a Morris Plains bill, all present passed it as such, 17 to 0. Consistency nowhere blushes more unseen than in legislative halls at Trenton.—Newark Evening News.

National Board Medical Examiners.

The following examinations will be held, as follows: Part I, June 25, 26, 27, 1923; Part II, June 28, 29, 1923; Part I, September 24, 25, 26, 1923; Part II, September 27, 28, 1923. Applications must be made on or before May 15 to Dr. J. S. Rodman, 1310 Medical Arts Building, Philadelphia, Pa.

Academy of Medicine, Northern New Jersey.

Stated meeting, May 16, 8:45 p. m. Paper by Dr. S. P. Goodhart, of Columbia University. Demonstration by moving pictures: (a) Patients showing interesting forms of nervous diseases; (b) Euccephalitis, acute and sub-acute symptoms; (c) Motor disturbances in neurological cases. Section of Eye, Ear, Nose and Throat meets May 14, at 8:45 p. m. Report of cases: Paper by Dr. M. F. Jones, "The Nasal Septum, Operative Technique."

Section on Medicine and Pediatrics, May 15, at 8:45 p. m. Reports of cases from hospitals by Drs. Petry, Asher, Rosewater, Vinciguerra and Herold.

Section on Surgery, Obstetrics and Gynecology, May 22, at 8:45 p. m. Report of cases. Papers by several surgeons; demonstration of unusual cases.

All the meetings are held in the Academy Building, 91 Lincoln Park, Newark.

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Any member failing to receive the paper will confer a favor by notifying the Publication Committee of the fact.

NOTE.—The transaction of business will be expedited, and prompt attention secured if,—

All papers, news items, reports for publication and any matters of medical or scientific interest, are sent direct to THE EDITOR, New Brunswick.

All communications relating to reprints, subscriptions, changes of address, extra copies of the JOURNAL, books for review, advertisements, or any matter pertaining to the business management of the JOURNAL are sent direct to THE CHAIRMAN OF THE PUBLICATION COMMITTEE, Newark.

157th ANNUAL MEETING OF THE

Medical Society of New Jersey

HADDON HALL, ATLANTIC CITY

June 21st to 23rd, 1923

Further Announcements in the June Journal

OUR ANNUAL MEETING.

All signs seem to indicate that the annual meeting of our State Society this year in Atlantic City will be the largest and one of the best ever held. The members of the Scientific Committee and the Committee on Program and Arrangements have given an unusual amount of careful thought and time to their work, and our President has been actively co-operating with them. We cannot at present give a detailed statement of the speakers and their subjects, but the printed program will soon be issued and sent to our members, and from information received we believe it will be worth receiving, consulting and preserving. We urge every permanent and annual delegate to attend, if possible, and an unusually large number of the wives or sweethearts are expected to be present this year.

Our Society should be well represented at the annual meeting of the American Medical Association in San Francisco,

Cal., in June. If any of the appointed delegates **cannot attend**, the president should be notified and if possible he should appoint others. Unfortunately, the date conflicts with that of our State Society meeting, but the oldest Society in the country should certainly have three delegates there.

The Editor, for two weeks before this Journal goes to press, has been working hard during the days and part of nights in assorting and removing from his office to his home a vast amount of furniture, books and other materials that have accumulated during the fifty-five years' practice of medicine, from which he has just retired. He gives this information in apologizing for any inaccuracies or omissions that may be discovered in this month's Journal.

TOO LAZY.

"If I were to name the one chief cause of surgical failure, in almost every case it would be laziness. Too lazy to take pains, too lazy to read books and journals, to visit hospitals and clinics, to attend medical meetings, to learn the newest and best methods. I have said long ago that a lazy man had no business to be a surgeon." Colcord, Pittsburg. Med. Bull.

This indictment, by a great surgeon, of his fellow surgeons, could be stretched to include all branches of medical practice. Who are the men who are NOT found in the medical society meetings? They are the men who have gotten fat and complacent, who consider that their knowledge is far superior to that of their confreres, that they can learn nothing in the county society meeting. This class and the still more ridiculous doctor who, recently out of college, feels his oats to such an extent that he is entirely self-satisfied, are the ones who cannot find the time to attend serious discussions of medical matters.

Too lazy to read! We recently observed a supposedly well-informed doctor making surprised inquiry about a method of treatment which has been in the current medical literature for two years or more. He had never seen it!

Too lazy to visit hospitals and clinics! There is not a doctor living who can keep well-informed by reading and practice alone. Yet many a prominent surgeon and physician has not spent a month in clinical observation in five or ten years.

Too lazy to attend medical meetings! His license should be revoked. He CANNOT

be sufficiently well informed to take the lives of people into his hands.—Southwestern Medicine.

THE HIGHER EDUCATION OF CHIROPRACTORS.

What is your favorite light literature? Detective stories? Mystery stories? Humor? Have you ever read the publications issued by the various species and subspecies of the chiropractic cult—for there is, as you know, a lack of unanimity among the chiropractors. One particularly choice piece of contemporary journalism is issued by a chiropractor factory in Fort Wayne, Indiana. Its July, 1922, issue makes good hot weather reading. The editor discusses a "model bill," recently drawn up by those chiropractors of Indiana who belong to a different subspecies from those represented by the publication in question. This Fort Wayne journal views the bill with disfavor. It says, with refreshing naivete:

"To begin with there is absolutely no need of a Chiropractic licensing and examining board in Indiana today. The existing lot of Chiropractors in Indiana cannot be improved upon. You are not being persecuted or prosecuted, you are left severely and strictly alone to practice your profession without let or hindrance from any source or any group of any kind. In fact, Indiana today is the best Chiropractic state in the entire country. Chiropractic conditions are as near ideal as it is humanly possible to approach that condition.

But the fact that Indiana is the home of the free, chiropractically speaking, is not the only objection this journal has to the proposed bill. It seems that the bill would require applicants for chiropractic examinations to submit satisfactory proof of the possession of a preliminary education, equal to that of a high school. Perish the thought! As the editor says:

"How many Chiropractors in Indiana today could qualify under that rule? Of all the Chiropractors in Fort Wayne, I do not happen to know one that is a high school graduate. In fact, I believe that the total number in Indiana able to comply with that ruling would be less than two per cent. of all the Chiropractors in the state."

From the point of view of the owner of a chiropractic "college" the sentiments

just quoted are eminently logical. It would be entirely unfair to chiropractic schools to insist on matriculants being educated human beings. What educated human being would ever attend a chiropractic school? Of course, from the point of view of public interest—but that's another story.—A. M. A. J.

The Editor was very sorry to hear of the death of Dr. Douglas, the faithful treasurer of the Morris County Society for many years, but the news came some days after his death. The Journal should be promptly notified of every death of our members.

New England Country Doctor

In this winter of heavy snows in New England the country doctor has been subjected to unusual hardships. With hill roads blocked by drifts for days, and sometimes weeks at a time, he has to resort to many expedients to reach patients in isolated farmhouses. The use of snowshoes has been common, and one physician had built a special ski-runner equipment for his motor car. One of the outstanding feats of perseverance in the face of difficulty and danger was that of Dr. John H. Riley, the oldest physician in North Adams, Mass. The January snowfall in North Adams was thirty-nine inches, and in the outlying towns among the Berkshire Mountains the wind swept the snow into huge drifts. Early one evening, when a blizzard was raging, Dr. Riley was notified that a little girl was apparently dying of pneumonia in a farmhouse on the side of Florida Mountain. A boy who had managed to work his way down over the half-broken out roads in an automobile brought the word.

Dr. Riley immediately started out with the boy in the car. A high wind was blowing, and when they reached an exposed point on the main highway, the snow had drifted so badly that the car stalled. The physician, wearing a heavy fur overcoat and carrying his medicine case, started on foot up the mountain toward the farmhouse, several miles distant. On his way he met two men walking down. They urged him to turn back, declaring that he could not get through the storm alive. He refused. After he had gone some distance the boy, who had succeeded in getting the car started again, overtook him. They were able to drive to a schoolhouse, a mile and a half from the farm where the girl was lying ill. There they ran into drifts that stopped all further progress. The highway to the farmhouse from this point was hidden under snow many feet deep, and Dr. Riley, familiar with the region, struck into a wood road, where the forest provided some protection from the gale. Plodding along slowly, he suddenly found he had missed the trail, and brought up against a barbed-wire fence. He followed the line of the fence for some distance, but could not relocate the wood road. He was almost exhausted and was on the point of discarding his overcoat to lighten his burden, when he saw the light of a swinging lantern. He shouted, but the

sound of his voice was drowned by the wind. He stumbled toward the light and finally came up with the bearer of the lantern, a young woman of the sick child's family. She had ventured out in the hope of meeting him. After Dr. Riley had done all he could for the sick girl he borrowed dry clothing, walked down the trail to the schoolhouse, and came back to North Adams with the boy in the automobile. He had been at home but a few minutes when another call came for him. A woman was dying in Clarksburg, several miles distant. He started out without hesitation and was able to make this trip in his car. When he got back, long after midnight, he was nearly worn out from his experiences, but the next day he was attending to his calls as usual.—Exchange.

SOMERSET COUNTY'S ACTION ON SENATE BILL 143

The following is a copy of a letter which our society instructed me to send to the Welfare Committee of the State Society.

The Somerset County Medical Society has received from the Welfare Committee of the State Society a typewritten copy of Senate Bill No. 143. While we approve of the objects of the Bill in general, we cannot but disapprove of it in its present form for the following reasons: We believe no such legislation should be introduced until after a free discussion at a meeting of the State Society and, as no emergency exists, the matter can well be left until the state meeting next June.

To quote the language of the bill "Either form A or B shall be filled out and signed by a physician licensed to practice medicine in this state in support of the declaration of the above applicant." We believe that in order for the law to be of any value an examination should be made in each and every case by a physician and if form A could be used the physician could be misled by the statements of the applicant who might or not be acting in good faith. Without a physical examination form A might as well be made out by the registrar or other officer issuing the marriage license. A layman could receive and write down statements just as well as a physician.

To quote again "The physician to, or appointed by, the local board of health shall upon request make the necessary examination and issue such certificate if the same can properly be issued, without charge to the applicant."

We unqualifiedly oppose any such legislation of this nature first, because an examination of this kind made free of charge by a public medical officer is nothing but the practice of medicine by the board of health which in our opinion is never legitimate and should always be opposed instead of proposed by our State Welfare Committee. Again no provision is made for compensation of the board of health physician. We believe that the state has no legal or moral right to demand the professional services (uncompensated) from a physician any more than from an engineer or architect.

Any applicant for a marriage license who is so poverty-stricken as to be unable to pay for a medical examination should be refused the license on every ground of economic and common sense unless such marriage is made as a result of a court order.

Finally, no way is provided for persons who, while suffering from venereal disease may be stricken by accident or intercurrent illness who may have excellent reasons for desiring to contract a death-bed marriage.

Very truly yours,
Philip Embury, Secretary.

Dr. Eagleton's Replies to Somerset County Society's Action and Monsignor Sheppard's Statement.

My dear Dr. Embury:

I will take up the objections of the Somerset County Medical Society, as I feel that they do not understand the matter. When the Welfare Committee was formed this year, we tried to put one member from each county medical society on the Welfare Committee, who had given support in the work. You will remember that you, yourself, were a member of the committee two years ago. It is unfortunate Somerset was not represented on the committee.

As chairman, I extend an invitation to Somerset to send the name of a member to serve on the committee, so that all the work of the committee can be known immediately by the society.

In your first objection you state that you approve of the object of the bill in general, but disapprove of it in its present form, for the following reasons:

1. "That legislation should be introduced only after free discussion." In answer, I would say these same bills, slightly modified, were introduced by the Welfare Committee in the name of the Medical Society of New Jersey one year ago, after a general call to all the societies to send representatives to Trenton for discussion had been issued. About fifty men from all the State responded to this call and the Venereal Control bills were there thoroughly discussed. They were defeated last year by being locked up in a committee of the Senate, after having passed the Assembly. If you will read the report of the Welfare Committee, delivered at the last annual meeting of the State Society, you will see that their re-introduction this year was advocated in the strongest language possible. Following the annual meeting, the bills were under discussion by the Welfare Committee continuously, and so that all members of the Society should have an opportunity to be heard, one general bulletin called attention to the fact that they were to be introduced. Every member of every county society had that bulletin. Consequently this was the second time that all members of all county societies were given an opportunity to offer suggestions, objections or indorsements. This has been the policy of the Welfare Committee since its formation, to try to make every man in the State feel that he personally was being consulted, and to encourage discussion in the county societies themselves, as well as among the representatives of the Welfare Committee. If I had not been ill at the time of your meeting, in which you passed the adverse resolution, I would have gone to Somerset County personally to explain the bills, as I did to several other county societies.

2. You object to Form A, and say: "We

believe that in order for the law to be of any value, an examination should be made in every case by a physician. Without a physical examination, Form A might just as well be made out by a registrar. A lay man could receive and write down statements, just as well as a physician."

I take exception to this statement. Ambulatory cases are frequently diagnosed without a physical examination. Certain it is that the asking of questions by the physician in his office that generally leads him to make a physical examination for venereal diseases. Form A was put into the bill, so that physicians could give women, with whose personal life and character they were familiar, a certificate, without an examination. Many of the western States do not require any certificate for women. I personally agree that it would be desirable of an examination in every case of marriage in the male. In the present state of public opinion such a provision would have doomed the measure to certain defeat.

If you would see the bill in the light that it was proposed by the committee you will see that it pays a great compliment to the physicians, as per the enclosed letter to Monsignor Sheppard, who objects to any examination or any certificate. The bill endeavors to put it up to the physician, whether he should demand an examination or not. Instead of being opposed to it, the profession should accept it as a high compliment. One of the ludicrous things about the matter is that you physicians objecting to it on the grounds of your letter, and Senator Simpson, who lead the opposition in the Senate, stating that their opposition was that the the doctors were trying to pass this measure to give them money and more power.

3. You object to the local board of health officer issuing a certificate without being properly compensated. I agree with you. The majority of health officers in the cities have a definite salary. In the smaller communities, where they serve without pay, they should certainly be recompensed.

The attitude of your society is well taken about all health officers. They should be adequately compensated for their work.

You say that: "An examination of this kind made free of charge by the public officer is nothing but the practice of medicine by the board of health." You are taking an entirely different view from that of the Welfare Committee. You do not object to the diphtheria cultures examinations, or school children examinations being made, or the treatment by the health authorities of smallpox or scarlet fever, all to prevent the spread of communicable diseases. This bill aims to prevent the spread of communicable diseases. This bill aims to prevent the spread of communicable venereal diseases to an innocent women and unborn children. I have not heard of Somerset County opposing the establishment of rehabilitation clinics, or of the State giving these clinics \$100,000 a year to conduct them, which is **the practice of medicine** by the State.

I agree with you that any person who is so poverty-stricken as to be unable to pay for a medical examination should not marry. However, that is a question entirely outside

the health problem, and we, as physicians, should confine our efforts to health problems, not economic ones.

And lastly, I agree with you that there should be provisions for death-bed marriages. In my opinion, this last objection is the only one that is in the least valid.

Your Welfare Committee has given the medical profession the best that is in them, at great sacrifices of time, money and thought. The Venereal Control bills were advocated by the Welfare Committee primarily to help solve medical problems, which is our duty, as physicians of the State; and secondly, to show the public that the medical men were trying to do something as citizens. These health measures have had fortunately a very good influence on the public, for the public is perceiving that the doctors are trying to help the community to solve health problems without thought of pecuniary recompense to themselves. It is the misfortune of the profession that a small proportion will always look at the thing from an individual standpoint; not from the larger viewpoint of the public good.

Having assumed the responsibility of writing to your Senator, asking him to vote against the bills—Somerset and Salem County Societies are undoubtedly responsible for their defeat. At the time of our poll, before Somerset and Salem communications to your senators, we estimated fourteen votes could be counted on; three more than enough to pass them; eight of these were recorded in the affirmative at the time of the taking of the vote in the Senate—one, Senator Richards, was ill, and not present; your Senator, Case, and Senator Allen, of Salem, read your communications requesting them not to vote for the bill; both of these, we had reason to believe, would have voted for us, but for your action, and prevented others, whom we feel sure would vote for us, from voting at all.

It was your action that defeated the bills; this, of course, was entirely within your province.

Having assumed the responsibility of their defeat, it is only just that you now take up the problem, and as chairman of the Welfare Committee, I call upon your society to place before the next annual meeting of the State Society a plan for the control of venereal diseases, so that it may be discussed at the next meeting of the State Society, along with any other plans, for the health of the State, which the physicians of the State by their education, association and self-sacrificing ethics are the only ones competent to wisely and justly deal with. This we must do collectively, or else admit ourselves as a profession unable to agree on any health policy, and this, at a time when the laity are looking to us for leadership in health matters.

Yours truly,

WELLS P. EAGLETON, M. D.,
Chairman, Welfare Committee.

Right Rev. Monsignor John A. Sheppard,
Rev. and dear Sir:

In answer to your published statement regarding Senate Bill No. 143, "intended to delay the marriage of persons infected with a venereal disease in a communicable stage,"

and Senate Bill No. 144, which is an amendment to a State law, enacted during the war, for "the control of infectious diseases in a communicable stage," I would say that these bills have been presented entirely in the interest of public health. They are a step in the health conservation movement, which has been going on for years, which has succeeded in controlling the communicable diseases, typhoid fever, diphtheria and tuberculosis, and has practically eliminated smallpox and yellow fever.

From the first sanitary law until the present, any suggestion in the interest of the whole community, which would affect individuals suffering from any communicable disease, has met with the bitterest opposition. This opposition has not even yet entirely subsided, as shown by the continued antagonism to vaccination of school children, in spite of the wonderful benefits to all communities resulting from it.

The importance of legislative action for the control of venereal diseases was recognized by the Federal government during the war, when the public was shocked to learn that as high as 540-100 per cent. of the second million of drafted men were found infected with these diseases.

Senate Bills Nos. 143 and 144 were introduced by the Welfare Committee of the Medical Society of New Jersey. The medical men regard venereal disease a medical problem, believing that medical men alone, because of their training and experience, possess the requisite knowledge regarding these diseases and the best methods for their control. They alone are familiar with the heart-breaking unhappiness that accompanies them, and the physical and mental wreckage that follow in their trail.

Senate Bill No. 143 cannot offend an intelligent person, but the right of an infected individual to marry is denied during the stage in which the disease is communicable, thus preventing the transmission of a loathsome disease to an innocent person, and burdening the offspring with a handicap which causes early deaths in 50 per cent. of all untreated infected infants, and seriously impairs the mental and physical efficiency of the majority of the others during their lives.

In spite of your assertions to the contrary, legislative action, based on scientific knowledge, has been successful in controlling social diseases, as was most strikingly illustrated during the late war, when the frequency of these diseases was reduced from 540-100 per cent., at the time of the draft, to less than one-tenth of 1 per cent., at the signing of the armistice.

Venereal disease control laws are active in over thirty States of the Union; in six States the certificate of a physician is required before a marriage license can be issued. Much more drastic measures are now before the legislatures of Oregon and Illinois.

Senate Bill No. 143 does not require a physical examination of every applicant for marriage. Believing in the honesty and intelligence of the medical profession, Senate Bill No. 143 allows the individual physician to use his judgment whether or not a physical examination is necessary, thus making it possible for the physician to issue a certificate

of health "from the statement of the applicant" alone, so that uninfected persons need not be in the slightest degree offended. But the bill, on the other hand, expects a physician to refuse a certificate without a complete examination, when the physician has any reason to suspect that the applicant may be infected.

The Welfare Committee regard these bills as educational, as well as preventive; if we can but get the contracting parties to demand that they shall know that the one they are marrying is not infected, we will have made great strides toward eliminating diseases that are far more widespread than the public appreciate.

Yours truly,

WELLS P. EAGLETON, M. D.,

Chairman, Welfare Committee, New Jersey State Medical Society.

Welfare Committee

James Hunter, M. D., president Medical Society of New Jersey, Westville, N. J.; Thomas W. Harvey, Sr., M. D., Main and Hillyer streets, Orange, N. J.; John McCoy, M. D., 292 Broadway, Paterson, N. J.; Frederick Quigley, M. D., Town of Union, N. J.; Frank W. Pinneo, M. D., 439 Mt. Prospect avenue, Newark, N. J.; D. C. English, M. D., 65 Paterson street, New Brunswick, N. J.; W. J. Carlington, M. D., 905 Pacific avenue, Atlantic City, N. J.; Andrew J. McBride, M. D., 30 Church street, Paterson, N. J.; Henry B. Costill, M. D., 371 Hamilton avenue, Trenton, N. J.; George T. Banker, M. D., 400 Westfield avenue, Elizabeth, N. J.; Julia Mutchler, M. D., Dover, N. J.; A. Haines Lippincott, M. D., Cooper street, Camden, N. J.; James J. McGuire, M. D., 122 West State street, Trenton, N. J.

Essex County Isolation Hospital.—Dr. W. H. Areson presented to the Board of Freeholders the names of several doctors to serve as an advisory and consulting staff for Soho Hospital. They are leading professional experts, who will be on call when their advice or aid is needed. The freeholders have approved this advisory staff plan.

Mountainside Hospital.—The campaign for new buildings' subscriptions to raise \$800,000 has resulted in securing pledges for \$846,000.

Hospital and Home for Crippled Children has received a bequest of \$290,000 for a new building, which will provide forty additional beds. This hospital is located at Park and Clifton avenues, Newark.

Salem County Memorial Hospital.—Dr. W. H. James reports the following for the month of March: Admissions, 33; discharges, 36; births, 3; deaths, 4; operations, 14; xrays, 18; accidents, 17; ambulance calls, 12; patients treated at clinic, 49.

Bonnie Burn Sanatorium.—Superintendent J. E. Runnells reports for March, as follows: Since the last month 40 patients have been admitted, 23 males and 17 females. Thirteen of these admissions went to the preventorium.

Among these admissions were four re-admissions.

The admissions were classified, as follows: Pretubercular, 13; moderately advanced, 3; far advanced, 23; non-tubercular, 1. The largest number of patients present at any time during the month has been 259. Smallest number, 243. Present, March 29, 259. This number includes sixty children in the preventorium and seventy-one out of county patients.

Hospitals Treat 210,271 Patients.—William Fellowes Morgan, president of the United States Hospital Fund, reported recently that 201,271 patients were cared for in the fifty-eight hospitals of the fund last year, an increase of 5,990 over the previous twelve months.

Patients who were unable to pay the cost of hospital care numbered 41,310, these free patients remaining in the hospital on an average of fifteen days.

If the entire body of patients, their strength restored, were to form in a line, eight abreast, they would extend from the Battery to Van Courtlandt Park, he said.

Adjusting Civil Service to a Hospital Staff

The two vacancies recently occurring in important places on the medical staff of the City Hospital have been filled in a manner excellent in itself, as well as harmonizing with the principal of Civil Service. Mayor Breidenbach has selected physicians long attached to the staff who had served in the capacity of assistants to those whose places they have now taken.

Thus, in each instance, appointment was in the nature of promotion. Dr. Richard H. Dieffenbach, Jr., had been for years assistant surgeon to Dr. Carl E. Sutphen and, prior to the latter's illness, had taken care of all his surgical work. In like manner, Dr. Edward W. Sprague had served under Dr. Hugh F. Cook, who has resigned. According to the mayor's announcement these appointments set the precedent for future appointments to the staff.

Future adherence to the spirit of this method of selection, other relevant factors being substantially equal, is a good rule to establish. It would be hard to find any place where, more than a hospital, political or any other like influence is more completely out of place. Fidelity and demonstrated fitness are safe criterions to rely on in staff promotions. In these instances the eligible list of those available for selection was a good one all the way through, but the rule of orderly promotion seems to have been fairly applied.—Newark Evening News.

Deaths.

DOUGLAS.—At Morristown, N. J., April 17, 1923, Dr. James Douglas, aged seventy-eight years. Dr. Douglas was a permanent delegate to our State Society from Morris County. Further notice will appear next month.—The Editor deeply regrets that notice of death was

not received until three days after the funeral. Mrs. Douglas was critically ill at the time.

GRIER.—In Elizabeth, N. J., April, 1923, Dr. Edgar B. Grier, aged sixty-five years. He was born in Birmingham, Pa., a son of Dr. and Mrs. Lemuel Grier. He graduated from Princeton University, studied medicine and graduated from University of Pennsylvania Medical School, in 1883, practiced a few years at Altoona, Pa., and thirty-eight years ago removed to Elizabeth, was associated in practice there with his uncle, Dr. Joseph H. Grier, until the latter's death. He was one of the founders of the General Hospital's Clinical Society, a member of the Union County Medical Society, the State Medical Society and the American Medical Association; also the New York Academy of Medicine. He was director of the National State Bank; was a former president of the City Board of Education, a member of the Municipal Insurance Commission; of the Suburban Golf Club and a member of the Westminster Presbyterian Church.

Action of the Union County Society.

"The Union County Medical Society learns, with deep regret, of the death of Dr. Edgar B. Grier, a member of this society for over thirty years. Dr. Grier was a former president of this society, a member of its original milk commission, and at the time of death a member of the board of censors and a permanent delegate to the State Society. He was always present at the meetings of our society, interested in its discussions and proceedings and active on the side of ethical medicine.

"As a practitioner he was industrious, skillful and kind, and devoted of his time and means to visit distant clinics, that he might be better prepared to minister to the needs of his many patients.

"As a citizen he was active and energetic, displaying in the various positions which he occupied in the city an enthusiasm and civic virtue which was commendable.

"We lose a dear friend, and record on our minutes a page to his memory, and transmit to his family our deepest sympathy.

"(Signed Norton L. Wilson, Stephen T. Quinn, Horace R. Livengood.)"

Action of the General Hospital Clinical Society.

"The Clinical Society of the Elizabeth General Hospital desires to record the fact that in the death of Dr. Edgar B. Grier it has suffered an irreparable loss.

"Dr. Grier was one of the founders of the society and its first treasurer. He was ever a faithful and interested member, working always for the advancement of medical science. He labored untiringly to maintain a high standard of papers and discussion and was invariably first to encourage the younger men to take an interest and active part in the work of the organization. His precept and example will be constantly before us and his character a lasting inspiration to those of us who are left to continue the labors from which he has been called.

"(Signed) James S. Green, Arthur Stern, Alvin R. Eaton, Jr."

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ONE HUNDRED AND FIFTY-SEVENTH ANNUAL MEETING OF THE Medical Society of New Jersey

Haddon Hall, Atlantic City, June 21st to 23rd, 1923

THE MEDICAL PROBLEMS OF YESTERDAY*

Yesterday Being the Decade, from 1875 to 1885, the Last of the Pre-Antiseptic Period.

Thomas W. Harvey, M. D.,
Orange, N. J.

"Forsan et haec olim meminisse juvabit,"
which being so, let us reminisce a bit.

The most important of these problems arose from the general adoption of the germ theory of disease. None of them were solved without long and spirited strife.

You must remember that only in 1864, just fifty-nine years ago in April, did the French Academy accept Pasteur's refutation of the doctrine of spontaneous generation as final. From the days of Aristotle this question had been the football of theologians, philosophers and physicists, and it was Pasteur's brilliant experiments before the academy that established the principle that "there is no life without a germ." As a distinct development of his further experiments on putrefaction and fermentation and his study of the diseases of fowls, silkworms and grapevines, we had the doctrines of Listerism or antiseptic surgery. Although given to the world in 1867, these doctrines were not widely accepted or applied until more than ten years later. Many problems had to be solved before we reached the haven of asepsis. In fact, steam sterilization of dressings did not come into use until after this decade.

The theory that many diseases, particu-

larly those that are communicable, are due to the presence and the life activities of minute organisms in the body, which had been advanced by many forward looking physicians of the past was fully established by Pasteur. The problem was further clarified by the discovery of the typhoid bacillus in 1880, and the organism of malaria in 1882. Klebs discovered the germ of diphtheria in 1883. Intubation was introduced by O'Dwyer in 1885, and reduced the mortality of diphtheria markedly. The death rate of diphtheritic croup with tracheotomy was over 75 per cent. My own experience was that all of our tracheotomy cases died. Buttner and I did many of them. A few cases got well without operation, when treated with steam developed by slacking lime in the room, or under a tent, continuously for days with free use of emetics and whiskey.

We had to wait another five years for antitoxin, and immediately diphtheria, instead of being our most fatal disease, became mild and amenable, when treated early. Pneumonia was infinitely a less dreaded and fatal disease than at present. The introduction of antipyrine in 1884 gave us great hope that we had found a specific, almost as reliable as salicylic acid in rheumatism, which came into use in 1876. Koch discovered the bacillus of tuberculosis in 1882, but did not introduce tuberculin until 1890. As you can see, a decade very prolific of problems, of new methods and of new remedies. The tetanus germ was discovered in 1883, but the antitoxin did not come along until a later period.

*Read before the Orange Practitioners' Society, March 23, 1923.

In therapeutics, venesection had been forgotten. The "ten and ten" of calomel and jalap, dear to the heart of the Revolutionary surgeon, Rush, had been driven out by the preaching of "*similiar similibus*," and the slogan: "*The mild power cures*." This decade was the harvest season for the followers of Hahneman, and a most serious problem was how to prevent all of our most remunerative practice from being taken over by the "new school." "New" was a great warcry and it won out for a number of years. We put up a stiff fight to keep them out of the State Board of Medical Examiners, and eventually we failed. Moreover their influence was felt in a change of therapeutics that came along about that time.

Ringer of London published a very popular book on Therapeutics lauding the administration of medicines in fractional doses frequently repeated, and so we got our "tenth of a grain of calomel every hour" accomplishing the same catharsis, that we had when we administered ten grains for a dose. He also favored the use of ipecac in small doses frequently repeated, to relieve nausea, a frightful confirmation of the doctrine of "similar." About the same time Fraser introduced to the regular profession the seductive little tablets which he had been selling to the homeopaths, and many of us fell again for small doses at short intervals. Shortly after this decade the great specialists of New York began to hunger for some of the good fees that they might earn if the ethical fence was not so high. So they revolted from the A. M. A. and liberalized their State Society and provided in their code of ethics an allowance for consultations between regulars and irregulars in cases of emergencies.

The morbidity in emergencies in New York City increased tremendously; so much so that the high priests of the A. M. A. were scandalized and they excommunicated New York. After a time the Middle West found that they also had terrible emergencies, and they revolutionized the A. M. A. code of ethics, threw down the wall of exclusion, threw open the doors of the medical societies, and with outstretched arms welcomed the makers of emergencies, and then behold! the miracle! the schism disappeared: faded like the mist before the morning sun.

The local anaesthetic value of cocain was demonstrated in 1884, and sulphonal was introduced as the first of the coal tar hypnotics. Quinine was our antipyretic in doses of forty to sixty grains, and there

was much malarial fever for its regular use. It was selling for \$4.50 an ounce, and the other cinchona alkaloids were in general use, cinchonidia, cinchonina, quinidia, now used for cardiac fibrillation, then a weaker sister of quinine, and the black tarlike residue, chiniodine, used in dispensary practice because of its cheapness. Whisky was the standby in typhoid fever, one pint a day, and in consumption we combined it with castor oil. In pneumonia and all infections, particularly diphtheria and septic conditions, much alcohol was given.

In infant feeding we had a few cereal foods, such as Robinson's barley and granum. My own preference at that time was goat's milk. Our infant feeding was in a parlous state. It was in this period that we had the fear of the second summer, and a very real terror it was. I can remember the anxiety I had about my own children. Cholera Infantum was a common cause of death. The summers of that decade were unusually hot and humid; we used to send the children on the little steamboats to Rockaway and Coney for the day's trip, and while the babies improved the mothers got seasick. Many mothers took their children and rode back and forth on the ferry boats until the cool of the evening. It was not until 1886 that sterilization of milk was proposed. Certified milk did not come until 1894.

We were still treating cases of hang-over dysenteries among the old soldiers who had come out of the army uncured in 1865. We had frequent epidemics of dysentery at that time, which in the light of our present knowledge, we should consider to have been due to these carriers. Locally, one of our medical problems was the "hatters' shakes"—chronic mercurial poisoning—in which the symptoms were a progressive anaemia with gastro-intestinal disturbances with very severe tremors, no real paralysis, but great weakness. Cessation of work, K. I., and epsom salts, with iron and strychnine as a follow-up treatment would cure a case in three to six months, with quick relapse upon return to work. The cause of the poisoning was the vaporization of the mercury in the forming mill and at the kettle.

The first college demonstration of the new antiseptic surgery was given by the late lamented Detmold in the lecture room of the old P. & S. Building on Twenty-third street and Fourth avenue in the winter of 1877-78. Lister had fought and practically won his fight in London, but

New York did not immediately accept his principle nor adopt his practice. Indeed, it was at this time that I heard Sayre, the father of orthopaedics in New York, when the carbolic dressing ran low, call out to his house surgeon, "hand me that bottle of balsam which I used as an antiseptic before Lister was born." Detmold's lecture was a wonder. That old German military surgeon, a fine old type, who was more interested in demonstrating the mechanics of the new practice than in the principles involved, flourished around in a mist of carbolic vapor, and when one of the towels dropped on the floor of the old lecture room, where anatomical demonstrations had been going on in the hour before, the old gentleman picked it up and put it back into the wound, "*secundum artem*."

At this time the older surgeons, Valentine Mott, Willard Parker and Sims, the men who had learned their surgery and achieved their fame in the days before the blessings of anaesthesia had taken away the fear of surgery from patient and doctor alike, were being supplanted by their successors, Sands, James R. Wood, Sayre, Markoe, Thomas, all of whom took up the Listerian methods with enthusiasm; but it remained for the next in rank, McBurney, Hartley, Weir, Bull, and their congeners to work out the problem of antiseptic to its legitimate conclusion of asepsis. Of course I am telling the story as in New York, the same development was taking place in the other medical centers of America.

The first problem of Listerism, aerial disinfection, was soon solved after much travail in clouds of carbolic vapor and steam, in rubber clothing and boots. The interesting fact was developed that the air cleansed itself of micro-organisms by precipitation and gravity if it was left quiescent; or by active oxidation and ventilation if thoroughly open to the winds of Heaven. The new principle was established that it is what is introduced into the wound by contact that harms; so we have scrubbed hands, gloves, boiled instruments and sterile dressings.

The next problem was the character of the dressings; all kinds of chemicals were used. Carbolic was soon ousted from its high estate, even Lister himself gave over its use and introduced the cyanide of mercury. Gradually, step by step, the need of chemicals for keeping bacteria out of wounds was proven unfounded, and the antiseptic dressing became the rule. It is

interesting that some of Lister's strongest opponents helped to bring this about—even Lawson Tait—who scouted the idea of bacteria and the need of antiseptics, was so particular in using cleanliness in his work that he aided materially in establishing the truth of asepsis.

The improvement that immediately followed the introduction of Lister's principles into the great hospitals of the world gave a wonderful impetus to surgery, and many problems of operative procedures came to solution immediately. For instance, in the early seventies about the worst thing that could happen to a victim of a compound fracture of the lower extremities was to be taken to Bellevue. It was amputation or death. Year by year, following the introduction of Listerism into that institution there were fewer deaths and fewer amputations. At the beginning of the decade, in amputations we were leaving the silk ligatures, then in use, hanging out of the wound. There could be no primary union. Torsion of the arteries was resorted to, and special forceps devised; even the femoral was twisted without secondary hemorrhage. When catgut came into use as ligatures we could close the wound.

The principal problem in ovariectomy, our only laparotomy, was "*shall the stump be dropped or brought to the surface and sewed to the skin?*" This question lingered on for some years, even in the early days of abdominal hysterectomy there were those who still practiced the external treatment of the stump. Hernias were operated when strangulated, but the operation for the radical cure was not yet standardized and we had some queer solutions of the problem to try. Injections of the canal and sac with strong astringents, invagination of the sac and plugging of the canal with the sac.

Subcutaneous surgery had become very popular; tenotomies, esteotomies and vasectomies were generally made subcutaneously, in order to avoid infecting the wound by excluding the air and the ever-present germs of infection, and some very clever operations were made. Previous to the development of laparotomy, the dread of opening the peritoneal cavity was very real, and when Dr. Thomas, in 1876, presented in his clinic a woman who had had her uterus removed and had lived, we looked upon her as a *rara avis*. The patient carried a letter from her London surgeon warning any inquisitive Yankee doctor from using a uterine sound; at that time

the third hand and the sixth sense of the gynecologist, an instrument rarely found in any office today.

Owing to the influence of three great men in New York, Sims, Emmet and Thomas, the gynecologist of that decade was a real personage. He had many plastic problems to solve which seem not to be so numerous or imperative today. Nowadays the gynecologist has become a laparotomist, and because one of them found an ovarian cyst adherent to the gall bladder he claims the whole abdomen as his field and would push the general surgeon above the diaphragm. The obstetricians of that day were taught to deliver their women without uncovering them; catheters were introduced and forceps were often put on under a sheet. Strange to say, we owe it to the trained nurse to release us from that bondage.

The problems of abdominal diagnosis before the days of exploratory laparotomy were met by the cultivation of a very acute tactus eruditus. The introduction of the whole hand into the rectum, as practiced by Sands, has fallen into a deserved desuetude. Only a man with a very small hand could do it safely. Rupture of the rectum is said to have occurred.

The establishment, about 1882, of a large surgical supply factory in East Orange brought our local medical men into close relation with some of the experiments in making antiseptic dressings. Naphthaline and hydro naphthol were introduced to take the place of the irritating carbolic and the poisonous bichloride dressings. Between the periods of wet antiseptic dressings and of dry aseptic dressings, there was a period devoted to the study of dry dressings with drying powders, iodoform, bismuth, boric acid, various iodine vaporizing powders, the dry earth of Hewson, etc. The problem of sterilization and preservation of ligatures, particularly catgut, loomed very large during this decade, and many failures marked the numerous attempts made to solve it.

The Orange Mountain Medical Society was started in 1882, and in 1885 a member exhibited, at one of its meetings, a series of experiments in the preservation of catgut for ligatures and sutures. The most successful method was the hermetically sealed tube with a single suture preserved in alcohol. It was two years later that the present method of preserving ligatures was adopted by the manufacturers. At another meeting, a styptic cotton was shown, medicated

with acetic acid and properly sterilized; designed to take the place of the domestic wad of cotton soaked in vinegar, which was often used to check uterine and nasal hemorrhage.

The nursing problem was another of the things that took up much of a medical man's attention in that decade. In 1878 the first trained nurse came to the Oranges, a graduate of the first class sent out from Charity Hospital. We had a goodly number of motherly old women, white and black, who did monthly nursing, and who drifted into caring for the sick generally, helping out the family, "sitting up" with the patient at night. Many of them became very wise in sick room affairs, but they did not relieve the doctor much.

In 1882 we started our Memorial Hospital Training School, by one of the staff going out in his buggy and getting a young woman to come to the hospital to begin training at once. He brought her back in his buggy and she began at once. She is nursing now. There were only about five other training schools in the country at that time. The training consisted of one year in the hospital and one year of supervised nursing in private work. This gave us some very well trained nurses. The passing years have rather increased the difficulties of solving the nursing problems. The services of these trained young women having been found essential in many more activities than were ever anticipated during the first decade of their existence.

During this decade also, many new problems had to be worked out in State medicine. The State Sanitary Association was formed about 1872. Its most active member, Dr. E. M. Hunt, of Metuchen—with the support of the association—succeeded in establishing the State Board of Health, which immediately started to collect vital statistics. The members of the profession were asked to report their births and deaths, and also their cases of contagious diseases. The death reports were easy, the undertakers attended to that; but many of the doctors protested against being compelled to pay postage on birth returns. It was a very gentle law at first, but it gradually grew teeth. In fact, there was very little sanitary law on the statute books of the State or municipality.

A committee of the Common Council formed a Health Board, with the city physician as an ex-officio member. That personage served as poor and alms physician, attending physician at the almshouse, police

surgeon, health officer and secretary of the Health Board, for three hundred dollars a year. This board rarely functioned except in the event of a smallpox epidemic, which came occasionally. However, we made the first sanitary survey of any town or city in New Jersey. This was made of the city of Orange in 1884. In this report the location of every house, the number of its inhabitants, the location of the well, privy vault and cesspool were shown. These three necessities were found on every lot in the city. They have all disappeared today. The location of all deaths, and as accurately as possible, the number of contagious diseases were also noted.

Another problem for the doctor at that time was house drainage; now a plumber's or sanitary engineer's job. Every case of bad sore throat or diphtheria was charged to local imperfections in the house plumbing. Alonzo Clark described a "cesspool fever." The medical man was expected to look for the source of the infected air. Incidentally few bath rooms were free from a bad smell. Step by step, it was learned that this bad smell was due to improper ventilation of the waste pipes. It was fixture gas and not sewer gas that made the bad smell. It seems absurd today that there should ever have been such a problem.

About the same time the problem of water supply and sewerage in the Oranges came up for consideration. The first report on the sewerage was made in 1885, and the first work looking toward a public water supply was started in 1880. In the solution of these two problems the medical men took an active part, both in the investigation and the discussion of the best methods. Both of these preliminary reports were made by a doctor.

There is no doubt that in the early developments of public sanitation: the initiation of the movement, the development of the methods and the conversion of the public, was the work of the doctors, and this was particularly so in New Jersey, where most of the advances in practical sanitation had their birth in the meetings of the State Sanitary Association.

Another of the problems of this decade was the establishment of the State Board of Medical Examiners. This caused something of a row, because only a minority of the profession wanted it. That board has been a storm center ever since. This problem of the regulation of medical practice and the control of all claimants for the privileges of the physician will lead, I fear,

to even more obnoxious forms of paternalism in State medicine. Annual registration, for instance. In 1875 those who were registered as physicians to practice medicine had to have a medical diploma, granted after having been indentured as a medical student for three years and giving evidence of having attended two consecutive courses of lectures in an accredited medical school. All other practitioners were quacks, pure and simple, illegal practitioners. There were plenty of diploma mills and fake colleges, but no cults. Homeopathy we thought of as a schism. There were fire-eaters among the regulars who were calling them all kinds of names, but they conformed to the medical laws of the day.

Then was started the Supervisor of Medical Practice, called "the Medical Act," establishing the Board of Medical Examiners, and as a result we have them recognizing and legalizing as doctors all kinds and varieties of cults, with more to follow. In some States each has its separate board of examiners, in others, as with us, a single board with "fifty-seven different varieties" of healers sitting together, with only one common ground, that of calling each year for an extra appropriation. This problem of State supervision by the "Medical Act" should be taken out of the hands of the practitioners altogether. All persons who desire to make a living by practicing any form of the healing art upon the bodies or minds of our citizens should be compelled to go through the same door. The key to that door should be an examination in certain fundamentals, and should be in the hands of the State Board of Education. Those fundamentals should embrace certain requirements in general education, which could not be acquired except by prolonged study.

In addition, the examination should be on certain specific subjects, anatomy, physiology, chemistry, morbid anatomy, pathology—such pathology as is evident to the senses and not founded on dreams—diagnosis, general and physical, public health, covering causes of disease, sanitation, public and private, and medico-legal medicine, leaving out all reference to methods of treatment. Those who would practice surgery, obstetrics or dentistry, should have to give evidence of an apprenticeship in such work, and should receive special licenses. It should be part of the police function of the State to see that no others should be allowed to practice the healing art upon the bodies of our citizens.

When we consider that the same decade brought the doctor the binaural stethoscope, dry plate photography, the high bicycle, the phonograph, the telephone, the electric light and the beginning of electric transportation, it will be seen how wonderful the decade was. How much it brought of new things and how very intensely interesting it was to have been living at that time and to have had an opportunity to take part in things at their very beginnings. When a paper on the "Symptoms of Appendicitis" was an event and the operation for ectopic pregnancy was a wonder and a surprise to the surgeon. Lawson Tait made the first one in 1884.

One has to go back to the days of the Seventeenth Century to find a time when medicine had made such a jump forward. Surely a great structure has been built upon the foundations laid in this yesterday decade.

The medical man who begins his work today with so many problems solved, and so much of the surgical technique standardized, misses something, I think, of the things that are worth while in medicine, unless he embraces every opportunity for blazing new trails and improving old ones. There is abundant opportunity for both. There are just as many problems to be solved today: vaccines, sera, the wonders of radiant energy, the everwidening field of the surgeons. With Holmes we can still say

"How blest is he who knows no meaner strife,

Than art's long battle with the foes of life."

The old Hippocratic axiom is just as true today as it was fifty years ago, or as it was in the year 450 B. C., when first uttered.

"Life is short and art is long; the occasion fleeting; experience fallacious, the judgment difficult."

THE MEDICAL PRACTITIONER AND THE AMERICAN SOCIETY FOR THE CONTROL OF CANCER.

By J. E. Rush, M.D.,

Field Director, American Society for the Control of Cancer.

Among the most important public health problems confronting the medical profession today is that of cancer control. It is possible to make a division of public health movements into several groups, depending on the amount of educational work which must be carried out before the program can be successful. In one group we find such

diseases as typhoid fever, malaria and yellow fever, which may be controlled simply by educating a few individuals, who possess the necessary power in a community to place the program in operation, after they have been shown the desirability of such a procedure. This type of activity is relatively simple, because it depends upon the education of a few individuals. Unfortunately, the diseases that can be controlled in this manner are among those which usually do not exact from the populace the greatest economic toll.

Another group of diseases may be effectively dealt with through police power, and here again we depend on the education of a few members of any given community. For the most part the diseases which may be controlled by this means we refer to as "communicable," and usually they can be very effectively dealt with by placarding, isolation and quarantine.

There is another group of diseases which are not communicable, and in which the education of but a few members of the community is not sufficient to affect the mortality rate. Here we find cancer, which depends for its ultimate control upon the education of every single adult of the community, with reference to the early signs and symptoms of the disease, for only in its early stages is cancer curable. With the present attitude of the public to seek medical advice only when they are aware of distressing symptoms, they must be told that early cancer is usually painless, and that proper treatment cannot be instituted until they have sought the advice of a physician.

The medical profession is interested in all types of medicine, whether preventive or curative. As a matter of fact, there really is no hard and fast rule of demarcation between preventive and curative procedures, any more than there is a dividing line between the metals and the non-metals. The medical profession is interested in all problems of public welfare, but when it comes to matters concerning public health they are the only ones who, through tradition and training, are capable of handling the problems which present themselves for solution. It is the only profession at the present time that is engaged in real preventive medicine, and it is the profession of election for this type of work. Usually public health movements have been initiated by the medical profession, but in many instances the work has passed into the hands of the laity, because the members of the

medical profession have been pre-occupied with other important problems.

What we have said with regard to the attitude of the medical profession towards public health work clearly emphasizes the need of control by the medical profession of all public health movements. The profession is particularly interested in the problem of cancer control, not only because it is of great humanitarian interest, but because of the further fact that cancer is one of those conditions in which it has been clearly demonstrated that the medical profession is the only one capable of offering a solution. While sanitary engineers, epidemiologists and others may be of great value in the conduct of specific public health movements their training and experience does not make them capable of helping in cancer control. The slogan of the American Society for the Control of Cancer that "early cancer is curable, if you will but consult your medical practitioner in time," again clearly emphasizes that the physician is the only one capable of reducing the mortality from cancer.

Another interesting feature of the movement for cancer control is that the establishment of diagnostic clinics during National Cancer Week is of some educational value to certain members of the medical fraternity, because important points of differential diagnosis, between early carcinoma of tongue, for example, and primary luetic ulcer, are demonstrated. The cancer movement in this respect is one of the few that attempts to repay the physician for the great effort he has expended in its behalf.

It has been claimed by some of the unthinking individuals among the laity that preventive and curative medicine are diametrically opposed. They do not realize that there is, in the last analysis, but little difference between preventive and curative measures. For example, all physicians take blood pressures and make urine analyses during the course of a pregnancy, and not by the wildest stretch of imagination can this be interpreted as a curative measure—it is a preventive measure, pure and simple.

Through various educational movements, which are now being conducted to instruct the public with regard to conditions which are definitely preventable, the great mass of the people are gradually coming to realize that the physician must be looked upon as a teacher and advisor, rather than one who is to be consulted only when symptoms of a diseased condition have manifested them-

selves. The physician, too, realizes that this teaching attitude is appreciated by the public, for by this means he is able to prevent premature deaths among his clientele. Not only does he spare the patient in question for future usefulness, but, more important, he does not divorce the rest of the members of that particular family. The physician realizes that the most appreciative patient is one who, through early advice and proper instruction, has been saved from untold suffering and an untimely death.

All health movements if properly managed and ethically controlled by the medical profession will not only eliminate certain objectionable features present in some of them, as now conducted by the laity (who have no appreciation of medical ethics), but such activities will help consolidate the medical profession against the ever-increasing influence of the cults. It is true, that we, as a profession, do not heartily approve of certain public health movements now in progress, because they do not conform to our ethical code. If they were controlled by the medical profession this objection would be removed.

It must be realized that the cults never would have existed had the medical profession taken a definite stand against them, but realizing that "imitation is the sincerest flattery," we have allowed them to go on—to exploit the public until even the great mass of the people has recognized the lack of sincerity which prompted the various movements.

The proper extension of these ideals relative to organization, in order to control public health problems, contains within it the answer to the proponents of that most preposterous type of activity known as "State Medicine."

The organization for cancer control is dependent upon the activities of the medical profession, and, therefore, the units upon which the organization is built are the State and county medical societies. The whole movement has been endorsed and approved by practically all national, sectional, State and local medical and surgical bodies, because it is entirely controlled by the profession itself. In the perfected organization for cancer control we have the ground work to handle other problems of a public health nature be they ones already in existence or future ventures. By proper organization, too, we shall be in a stronger position to abort detrimental legislation, whether directed at us or to legalize the ignorant cults. A public health problem

directed solely by physicians will do more to properly organize the medical profession than any other type of activity.

It has been pointed out that if we do not seriously consider the "scientific attainments" of the cults, then every preventable death is a reflection on us. It has been claimed that the fact that the patient did not come early enough to us for examination and advice is no excuse—that we, as the only logical profession engaged in the practice of the healing art, should have the undivided confidence of the public to such an extent that they will report to us what are very trivial matters and thus give us opportunity to institute proper procedures in time. In the vernacular of the street, it has been suggested that we should "sell ourselves to the public;" which, in other words, means that there is at the present time a great need of ethical publicity on the part of the profession. It really seems that this would, to a very great extent, increase our usefulness to the community in which we practice. If this is true, then no physician can be so busy that he cannot devote a small amount of time to help in the campaign for cancer education, because by so helping he is not only advancing his own usefulness to his community, but is of the greatest value to his medical brothers and to his profession.

A few members of the laity have explained what they have interpreted as apathy on the part of certain of the medical profession toward preventive medicine by emphasizing the fact that preventive medicine was diametrically opposed to curative measures. We, of the medical profession, realize the fallacy of this. Let us consider an analogy from the field of engineering. Suppose that ten engineers were bidding on a contract to construct a road between two adjacent cities. Only one could be successful; but would the others put obstacles in the way to prevent him from completing his task? The answer is apparent. They would not; for they would realize that when the public had seen the value of this road they would demand similar ones in all other directions, and hence the other engineers would have an opportunity to build some of them. I realize that the above example compares a business conducted purely for monetary return, to a profession which interests itself chiefly with humanitarian efforts, but the very few of the public who believe that all persons are actuated by ulterior motives should be answered. The good roads analogy applies

directly to medicine, for the medical practitioner realizes that each time the public is convinced that it is unnecessary for them to suffer with various ailments they demand the removal of others, which, heretofore, they patiently tolerated. An example may illustrate this point:

A friend of mine, who for many years was almost an invalid from recurrent attacks of what was then diagnosed as "inflammation of the bowel," and for which, at that time, there was no known cure, was simply forced to allow the condition to exist, which undermined his health and lowered his efficiency. At the present time, because of the knowledge of the laity concerning chronic appendicitis, he would know that an operation, requiring him to be at a hospital for but two short weeks, would give him complete relief, and enable him to resume his life's work at a greatly increased efficiency.

Our medical ethics instituted at the time of Hippocrates admit of no change, but our interpretation of them may be broadened to meet the changing conditions; especially those which have been brought about during the past two or three decades. It may be necessary to change our ideas regarding proper non-personal publicity, for the medical profession as a whole and for our State and county societies. In this connection I am reminded of the story of the young color-bearer at Gettysburg, who had advanced somewhat ahead of the lines, and when ordered back to his position by his commanding officer replied: "Bring the line up to the flag."

THE SANATORIUM; THE MOST VALUABLE AGENCY IN THE ANTI-TUBERCULOSIS CAMPAIGN

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The tenth of this month marked the fourteenth anniversary of the writer's entry into the fight against the universal scourge Tuberculosis and during this time he has acted simultaneously in the roles of social worker, dispensary clinician, tuberculosis-class teacher, consultant and sanatorium director, and his studies have carried him from the source of contagion and development of the disease in the home, work shop, and public halls, through the diagnostic clinics to the battle ground of the sanatorium.

Considerably preoccupied with routine duties and what special work he was able to squeeze in, there was no time left to compare the relative values of the different agencies of attack being used against the common enemy. Indeed there was no reason for such a comparison for each agency had its own duties to perform and all were dependent upon each other in working out a well rounded program, except there were occasional adverse criticisms by social workers and visiting nurses to the effect that sanatoriums were falling down in the expectations of the community. During the past two years since withdrawing from active sanatorium practice he has had time and opportunity to view his past efforts in the perspective and in taking stock of the merits of the different agencies of offensive and defensive warfare against tuberculosis, it seems to him that in the sanatorium we have the means of contributing to the priceless state of health of the individual and the community in a far larger measure than in any other of the agencies which have yet been devised for the control of man's chief physical enemy.

The Dispensary is a diagnostic and medical treatment station, very important but decidedly limited in its scope of attack. The Visiting Tuberculosis Nurses distribute supplies and convey information by word of mouth and demonstration but they are handicapped by their necessarily infrequent visits. The Preventorium aims at pre-development in the exposed child, a plan most admirable in its concept and execution. The Day and Night Camps supplement the Sanatorium; and the numerous other health agencies strike only indirect blows at tuberculosis. The well organized Tuberculosis-Class combining dispensary work with instruction and keeping the physician in touch with the patients by frequent visits of the latter to the Class, and keeping home conditions under close surveillance by frequent visits of the Class nurse, approach our ideal but it has the obvious disadvantages of prolonged isolation of the patient, constant advice of well meaning but misinformed friends to relax discipline and the lack of inspiration due to association with improving patients. I repeat these agencies are all important and the value of none is to be one whit minimized. Indeed, we may think of them

as stones forming the metaphorical bridge which the invalid must traverse from sickness back to sustained health, but the Keystone, the one that binds the other together and completes and strengthens the bridge must be allotted to the Sanatorium.

What is the primitive reaction of an individual when told he has tuberculosis and what is the reaction of the neighborhood? That of the afflicted is to be well again and that of society is to put him away where he will do no harm to the remainder of the herd. Ameliorating influences of advancing civilization have mollified the original reaction of the herd so that we find today they gave him the opportunity of comfortable isolation until such a time as he can recover, provided in the interim he learns methods of preventing the spread of the disease to them upon his return to their midst. They also require that he shall attempt to restore his economical status that he may not be a financial drone upon his return. If in his place of isolation, he should unfavorably respond to afforded treatment it is a source of primitive satisfaction that his exit was from a comfortable environment where contamination was nil because of the natural preventatives of sunshine and oxygen. Thus we have in a concise and somewhat distorted way the psychologist's reason for a sanatorium. Practical sanatorium directors as are represented here today, state the same thing by saying that the duties of a sanatorium are primarily four, namely: (1) to arrest disease and produce symptomatic relief; (2) to teach cause, prevention and cure of Tuberculosis, and the maintenance of health; (3) to restore as far as possible earning and working capacity; and (4) to provide a comfortable and isolated place for those who are going to die.

This is a short program but elastic enough to be complete and forceful and before discussing it at length I should like to dwell upon some of the abstract requirements of a successful sanatorium without which its elevation and the beautiful scenery afforded thereby; the spacious grounds with their decorative lawns and flowers; the pretentious buildings of brick and stone, and the complete equipment and furnishings thereof, are a waste of money and effort and are of less potential value to the patient and community at large than a few little shacks

in the woods, with scanty furnishings and meagre medical equipment.

Foremost among these are the personality, intelligence and energy of the Superintendent. His shadow, or as it should be in this case, sunshine, covers the whole place and his master hand is seen everywhere. He must be a man of unqualified faith in the ability of his sanatorium to fulfill the hopes and reasonable expectations of his patients and he must be able to convince his whole staff and patient-body that satisfactory results have been and are going to be obtained. In this section of the country especially, his medical skill and judgment must be sufficient to offset the lack of climate advantages in the treatment of tuberculosis which exists principally in the minds of the laity. You have a wonderful health resort on your seacoast and convalescents from acute organic and functional diseases, come from all parts of this country and from distant countries to take advantage of the invigorating atmosphere of Atlantic City, but I do not suppose it would occur to a doctor of any other state to say to his patients "You have Tuberculosis and must go to New Jersey if you want to get well." Ever since old Dr. Galen, who practiced medicine during the first Christian Century began sending his patients to high and dry climates to dry up the secretions they were expectorating and which he held responsible for their disease, succeeding physicians without much thought of the other factors involved, economic and social, and without any thought to the changed and established scientific concepts of the pathology of tuberculosis have been sending their patients to similar resorts though they may be reached sometimes only after much fatigue and mental suffering and at the risk of losing what reserve strength is left. So thoroughly rooted into the minds of the people is the need to change to a different climate, preferable dry, that very often at great sacrifice they will move to the far West or to some of the closer renowned resorts and there without suitable medical guidance they plan their own regime, making climate the alpha and omega of it. I say that the establishment of sanatoriums in all sections of the country has been justified by the prevention of innumerable heart-pangs due to distant separation and the tremendous amount of physical energy

that has been conserved to fight disease. We physicians feel that a climate is a luxury to be considered only after every other need has been provided for. Those of you who have had the privilege of hearing Dr. Russell A Conwell's famous lecture, "Acres of Diamonds" will recall the gentleman of the Orient who hearing of the fabulous riches of Spain sold his farm and went in search of the El Dorado. One day a few years later after much fruitless wandering from place to place, broken in strength and courage, and money all spent, in desperation he threw himself into the sea. Just about this time a diamond field of untold value was accidentally uncovered on the old farm by the new owner. Weighed in the balance of public opinion, the climate of New Jersey is not especially conducive to the cure of Tuberculosis and to offset this presumed disadvantage you will have to over emphasize some of your disadvantages and utilize to the nth degree the tried and true therapy of Tuberculosis control. I see you swell in righteous indignation over the reflection upon your climate for you as sanatorium workers know of many cures that have occurred here and when we compare the statistics of English, Newcomb, and Pollack, with those of physicians of the more favored and distant resorts we find there is no marked difference in the ultimate results obtained in the different places. We know that the secret of successful treatment is the proper medical supervision of each individual case and a contented and co-operative patient. The means to heal tuberculosis are right here in New Jersey and it is to your credit that you are using them and are educating the people in the use of them. Their diamond field of restored health is here at home if they can be made to see it.

Again the superintendent must be able to inject his enthusiasm into his associates. Assistant physicians should be encouraged to engage in some sort of special investigation in diagnosis or in treatment. Encourage them to ride hobbies if they are justified ones. The patients are marking time or are dying and the staff members are already dead in the sanatorium where there are no hobbies and where only the old routine of eat and sleep in the open is carried out. Cultivate among your staff 'specialists' in different therapeutic activities—one may be a

specialist in heliotherapy, another in artificial pneumothorax, another in treating the intensely distressing laryngeal tuberculosis and because there is a psychosis among a majority of the patients of a sanatorium all should have special training in psychoanalysis and psychotherapy. The superintendent should have a heart in the biggest sense of the word—and furthermore it should be what Gilett Burgess terms an "Educated Heart." The September number of "The American Magazine" contains an article by that author entitled, "Have you an Educated Heart?" space does not permit a synopsis of this very humane article but the gist of it is that the "Educated Heart" inspired good deeds, furthermore it inspires them in a way to reveal their genuineness. It implies that one may perform many kindnesses but these may totally lack sincerity which is plainly apparent to the recipient. The "Educated Heart" performs a deed in a manner to appeal to the recipient and win his co-operation. I would appeal to you to educate your own heart if you have not already done so and require each member of your staff to do likewise. True kindness can be dispensed without patronizing and without compromising discipline and it is the first stepping stone to confidence and confidence begets co-operation and that in turn brings results.

Earlier in this paper it was said that the functions of a sanatorium are four, and the first of these is to "cure" the curable. What a friendly word "cure" is and what an inspiration it is to staff and patient alike. It is the English translation of the Latin verb "sano" which is the root word of sanatorium, which means literally "a place where cures are obtained." With the elevation of medicine to a science "cure" as applied to tuberculosis was tabooed and with its passing went an irreplaceable means of inspiration to many an invalid who stood wavering on the question of whether to will or not to get well. To be restored to health is the normal hope of every person in a state of temporary physical illness and when the terms of health are denied him his imagination soon visualizes chronic invalidism or death staring him in the face. Death becomes his choice. One of the stimulants we are justified in using is the phrase "clinical cure."

It is not my purpose to detail in this

essay the fundamentals upon which the arrest of Tuberculosis is based for they are well known to you and are depended upon by you for your results but there are three which to my mind form the tripod upon which rests successful therapy and which I should like to emphasize; they are mental therapy, rest and supervised exercise. I do not underestimate air, food, medicines, and special methods of mechanical therapy for they are vital and must be a part of our treatment. Especially do I want to condemn the contempt shown toward medicines in some sections among general practitioners and even sanatorium physicians. This is a legacy of the period when Tuberculosis was called consumption and consumption was incurable inasmuch as it was due to an inherited or acquired tumor in the blood. The writer frequently sees patients and so do you who have suffered and lost ground because rational medical therapy has been withheld from them. To be sure there is no specific but to condemn all medicines on this basis displays an ignorance that undoubtedly results in symptomatic suffering and obstructs healing.

In my tripod I have placed mental therapy first, chiefly, because it must be used throughout the patient's career in the sanatorium. Cross currents of conscious and subconscious ideas are at work from the time he enters the door and goes to bed until he leaves a well man or a chronic invalid, that will determine to no small degree his response to treatment.

We do not understand fully the biochemical changes that take place in the body cells as the result of external impressions but that such changes do take place is manifested by a state of grief, sorrow and despondency when the "news" is bad and joy, happiness and hope when the "news" is good. We cannot accurately explain the molecular activity caused by disease to produce a change in the individual temperament but that such happens is shown by his moods in the presence of fever, sweats, and other evidences of disease activity. Docile, kind and considerate before illness the patient becomes sullen, critical and even antagonistic toward doctors, nurses, and friends, during a state of toxemia. If impressions and disease affect cellular activity in such a manner as to alter disposition is it not reasonable to believe

that impressions to a certain extent will cause a molecular shake up that will weaken or strengthen the tissues at the very point of contact with the invading organisms? I do not believe we as physicians have given this feature of illness as much consideration as its importance demands but we have supinely permitted cults to practice mental therapy and take from Medicine fruits rightfully belonging to it. If this paper does nothing more than create an interest in psycho-analysis and therapy its writing will not have been in vain.

I am well aware of the opinion that the tuberculous are a cheery and hopeful class but close observation and study do not substantiate this. Careful quizing of the individuals with active diseases who are apparently cheerful will usually reveal that the toximia is temporarily stimulating them; that they are wilfully assuming a hopeful attitude or that they are receiving encouragement from some source.

The next fundamental of "the cure" I want to emphasize is **rest** and I do this because of the growing tendency in some quarters to convert the treatment of tuberculosis into the "work cure" in contradistinction to the "rest cure." Sanatorium treatment should begin with a preliminary period of rest in bed for a month to six weeks whether or not active symptoms be present. This not only properly introduces the patient to Sanatorium regime and discipline but it makes an impression upon him that he will never forget. Long after he has returned home the initial bed rest as a means of treating activity will be uppermost in his mind. It is easier to train a patient in bed. If symptoms of activity are present the preliminary period of rest should last until they disappear or are considerably diminished. Local symptoms such as cough, expectoration and shortness of breath will perhaps persist longer than constitutional ones such as fever, fatigue, tachycardia and gastric disturbances. Fever is the most constant symptom of activity but it may not be the most pronounced, therefore its height should not be the sole index to rest in bed. Its amplitude is almost as important. Persistent blood spitting, persistent loss of weight, pleurisy and indigestion indeed the appearance of any symptoms which may or may not be interpreted as being tuber-

culous in origin should indicate bed rest until they clear up and the "threatening storm" has passed. The principal of rest is based on sound physiological reasoning. It limits general muscular activity and immobilizes considerably the movements of the lungs. This of course limits tissue movements at the site of disease and thus acts as an antiphlogistic. We may reason that there is an actually diminished normal cellular activity at the point of contact with bacteri and disease. Furthermore rest favors conservation and the cellular energy necessary for body motion and activity can in some means be utilized as tissue resistance. Therefore, rest must be utilized as often and as long as observation of signs and symptoms indicate its need. During this period or rest which inferentially is the period of disease activity that only form of occupation permissible is mental occupation. Keep the patient from getting lonesome, restless, and despondent, by mental diversion or in other words phychotherapy. The only possible exception to this rule is when the advanced case after a prolonged period of observation demonstrates the improbability of any chance to recover.

These hopeless cases can be given more latitude in exercise. Bed rest is difficult to enforce sometimes and unless the patient has the physiological reason of it explained to him, he can hardly be expected to voluntarily cooperate. Where can this and the reason for the other innumerable rules so necessary for arrest, prevention and control of Tuberculosis be better explained, reiterated, and demonstrated than in the sanatorium. After convalescence commences, and frequently it is fluctating and uncertain and subject to many set backs, we resort to small graduated amounts of physical exercise which brings us to the third point in the process of cure which I wish to emphasize. This may consist of any number of pastimes and occupations that are recommended but with the idea always in mind of keeping from two to three physiological steps behind the point of possible disease stimulation and toxic reaction. For the more fastidious class of patients, toy making, chrocheting, walking, horticulture, classes in natural history and out-door games as croquet and "putting green" may be prescribed but something more practical and fitting for their early return home to a means of livelihood may

be resorted to with the working classes.

The second duty of a sanatorium is to teach its patients facts about tuberculosis as a disease of the individual and as a public health problem. It is not sufficient to distribute leaflets and booklets of "health hints" and "do's and don't's" and depend upon this literature as the sole means of intimately acquainting the patients with the disease that so vitally concerns him. These are alright as references but the most effectual method of teaching hygiene is by tactfully criticising individuals and groups at the time a transgression is committed and then explain why the deed constitutes a breach of sanitation. Observance of rules should be noticed and favorably commented upon in the hearing of groups. These informal talks made during 'rounds' should be supplemented with regularly scheduled talks given weekly in the assembly hall by a member of the staff. These talks are most impressive when illustrated and they should cover the subject matter of a grammar school text-book on hygiene and sanitation. The doctors, nurses, and dietician of a small sanatorium can very well handle this feature but in a large one the bulk of it should be done by a professional teacher who can also be a teacher in reconstruction or in the children's hospital school. In this connection I want to heartily recommend the Modern Health Crusade literature as a part of the curriculum of your children's hospital school. As a means of getting health information to children it is unexcelled. We must remember that every day a patient is in the sanatorium he is learning something about tuberculosis from co-patients or others, either right or wrong, which he is going to take back home with him when he leaves, and it is incumbent upon the superintendent to see to it that the information is right that the patient may intelligently maintain his own health and prevent the spread of tuberculosis. The community from which he comes has a right to expect that he be given this information.

The third duty of a sanatorium is to restore earning and working capacity of its patients. By instituting and maintaining properly conducted and medically supervised classes in occupational therapy and vocational training the sanatorium assists the patient not only to re-

store his tissue strength but to regain his ability to earn a living. The community thinks well of a sanatorium that prevents the development of industrial drones. Graduated work converts the fat of the reclining chair into the sweat of the brow. We have the Government to thank for the practical demonstration it was able to give of the beneficial effects of occupational therapy on a big scale. Surgeon F. C. Smith, U. S. P. H. S., (now assistant Surgeon-General) was early impressed with the value of graduated exercises as it was prescribed in a limited way in some of the civilian institutions and in his capacity of Chief of the Tuberculosis Division of the U. S. P. H. S. he established the machinery throughout Government sanatoria which made this potent agent a part of the treatment of the ex-service man. "Occupational Therapy" became the parent of "Vocational Training" through which many partially disabled ex-service men are being restored to productive and independent citizenship.

The methods of occupational therapy are legion and require no enumeration here but suffice it to say different sanatoriums will find different methods more suitable to their needs and location. As a sanatorium director and an economist I preferred that form of exercise that not only benefitted the patient but reacted as well to the economical benefits of the institution. This is obviously dangerous therapy, however, requiring close personal supervision and is not to be recommended indiscriminately. Drs. Marcus Patterson and Herbert M. King, however, showed convincingly in their instructive papers, how successfully graduated patients exercise could be retrobeneficial to patient and sanatorium. Where a professional teacher must be used and the medical director cannot devote a good part of his time to this therapy, it is safer to adopt means of exercise that have limited relation to sanatorium administration and debatable commercial value as in the first instance the patient may be overworked and in the second he may voluntarily overwork. There are several reasons why all paid employees of the sanatorium should be recruited from the ranks of physically and mentally suitable patients. Chief among these reasons it permits a number of convalescents to pursue the remainder of their lives in the best of environments and promotes a

loyalty that cannot be found among "employees from outside." Among the pleasant recollections of my tenure of office at Eudowood Sanatorium is that a large part of its daily work was carried on by arrested patients, many of whom performed responsible chores they had no knowledge of prior to their treatment and sanatorium training. There is a form of vocational training available in every sanatorium of 100 patients or more whose potential possibilities in the sanatorium and in the field at large, I am afraid are not fully appreciated and that is the training of patients as nurses. I venture to say that every sanatorium physician here has worried gray hairs into his rapidly balling head over the quest of nurses while daily he has been sending back to occupations of questionable suitability young women mentally, physically, and temperamentally suitable as trainees for the job. Furthermore the prospective trainee has had an experience thrust upon her that makes her undoubtedly more fitted for duty among the tuberculous than the nurse from the general hospital has had. The general nurse of superior qualities does not voluntarily take tuberculosis cases except under pressure and only will the fascination of the life inspire her to accept a sanatorium position and that usually in the capacity of supervisor. This means that the sanatorium is forced to employ in its ranks nurses who in the main cannot get employment in general hospitals or who through illness must seek the sanatorium regime. (I hope I do not belittle the great sacrifice and heroic work of those capable women who have gone into this work voluntarily.) I want to suggest that every sanatorium physician and nurse tentatively select those young women whom they feel qualified as trainees and either train them in their own schools or refer them to a well conducted school in some other sanatorium. They will not only help relieve the shortage of good nurses in sanatoriums but will confer a kindness upon the patients by showing her a way to a vocation that is pleasant and profitable and one that is lived in an atmosphere which her special handicap requires.

The fourth duty of a sanatorium is to provide a comfortable place for the dying cases. This is not only humane, it is also prevention. Humane because it assures

the patient of medical and nursing service that the average household cannot give him. It at least assures of him a comfortable ending. Some sanatoriums send their patients home when the end is in sight. Except when the patient or relatives demand his release a dying patient should be kept at the sanatorium. It is true that such an one during his last days may contaminate his surroundings with massive doses of infection which can be better counteracted in the sanatorium than in the average household. If children are at home every means should be exerted to prevent his return.

In conclusion, when we summarize the essentials to control and exterminate the great scourge tuberculosis we find that there are many contributing agencies absolutely vital to a successful program and it is not the purpose of this paper to minimize the efforts of any of them, but in the Sanatorium it would seem we have the opportunity to exercise these requirements. Isolation, Treatment, Education, Rehabilitation in a manner that cannot be equalled by any other type of institution.

REST AND EXERCISE IN SANATORIUM TREATMENT OF PULMONARY TUBERCULOSIS.

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In a review of the papers presented before the National Tuberculosis Association, we find over a hundred presentations concerning some phase of the treatment of tuberculosis. In each of these there is some discussion of the value of rest and exercise, but in only four essays is there any attempt to treat this important subject in a comprehensive way. I likewise feel some hesitancy in giving expression to my views upon this very difficult subject, but will give the methods employed by me in the various institutions with which I am connected as well as in home treatment.

It is not my purpose to consider this subject from the view-point of the specific manner in which rest cures a lesion nor do I wish to offer an explanation of the effect of exercise in producing auto-inoculation and the like. For several years it has appealed to me that the rest period, as practised at the average sanatorium, was far too short and

that exercise was not properly regulated. Every one of us has had the experience of failure in preventing relapses during treatment and all have diligently sought the method which would restore the invalid to an earning capacity in the shortest possible time.

Brehmer, the father of the modern method of the treatment of tuberculosis, did not fully grasp the importance of properly regulated rest and exercise. His pupil, Dettweiler, showed far more vision in handling the subject of rest in the open air, while Trudeau probably did more than any other man to put the rest treatment on a scientific basis. Paterson's work on graduated labor has been of great assistance in outlining the scheme of prescribing exercise, but I know of no institution employing his exact methods today.

We must not lose sight of the fact that most every discharged sanatorium patient is expected to go back to useful work, and further that the problems in the relatively well-to-do and the working classes are quite different. The large percentage of sanatorium cases falls in the latter group. It is generally accepted that the safest indication of arrest of disease is the tolerance to at least four hours of daily exercise for a period of six weeks without any evidence of activity. It is preferable that the patient do not leave the institution until he is able to exercise six hours daily and this can best be regulated under the eye of a capable and enthusiastic sanatorium physician. It is true of rest also that its successful application depends upon the enthusiasm with which the physician explains its workings to the patient. There are physical and psychological advantages of bed-rest in the beginning of treatment and properly regulated exercise brings forth the same benefits at a later period of treatment.

For a number of years it has been my misfortune, as well as of others, to observe that many patients attained a state of apparent cessation of activity during prolonged periods of rest, and yet definite signs and symptoms of a flare-up appeared when exercise, of even the shortest duration, was prescribed. Since employing the method of regulated exercise, which I shall describe later, I am convinced that these reactions have been observed much less frequently and, although the method has been in use by me during only a few years, the patients

seem to have returned to their former occupations without the usual number of relapses. The work of Sewall in which he roughly advised rest on alternate days has been of great assistance to me in arriving at the plan employed the past eighteen months.

While it is true that rest is most important in bringing about healing of the lesion, exercise forms the basis of the return of the patient to useful occupation, and there is a combination of exercise with periods of rest which later may permit of our bringing about this result in a time shorter and safer than has been formerly prescribed. Exercise consists in walking and working, and the latter may consist of either the light or heavy variety. One must be careful in prescribing certain forms of work, bearing in mind that some individuals are unaccustomed to manual labor. The physician with interest in the problem can persuade most any patient to take an interest in one of the branches of occupational therapy such as knitting, weaving raffia, crocheting, embroidering, making reed basketry, studying, picture-framing, photography and the like. When it comes to ordering work in the house, garden, or field, due regard must be paid to the temperament of each individual. My enthusiasm in the method employed in more recent times has met with hearty response in practically every patient and the results as viewed by those assisting me in the several institutions encourage me to continue my present plan.

Before taking up the question of rest and exercise in detail, I wish to acknowledge my indebtedness to the writings of Kinghorn and Pratt on the subject of the rest treatment, while much concerning the proper employment of exercise has been gathered from the writings of King and Mills, Foster and Sloan. The point often brought up is how long should the patient have bed-rest. It is my practice to keep the patient at rest until all activity ceases and then to further continue the bed-rest for a period equal to one fourth the time it has taken for the activity to cease. If it has been a month, a week longer of bed-rest, and if it has been a year, three months before sitting up is permitted. Physicians differ as to activity, some depending upon symptoms, some depending upon physical signs, while the majority give due consideration to both

symptoms and signs. Activity is usually present when the temperature continues above 90 degrees in the male and above 99.2 degrees in the female. This holds true generally when the pulse-rate is over ninety in the male and one hundred in the female. Blood-spitting and pleurisy constitute definite evidences of activity and require rest before exercise is instituted. Marked cough and expectoration, especially if associated with gastric disturbance, are indications for continuation of bed-rest. Sweating during the sleeping hours of the adult should be an indication of activity and the proper rest in bed is to be ordered. Physical signs are less of a guide to activity and should always be secondary to symptoms in estimating the period to interrupt bed-rest.

Some cases come under our observation in sanatoria and we find, on admission, that they are either inactive or become so within a week. My practice is to keep such patients at rest for only two weeks and then to begin sitting-up exercise at a rate double that of the case of activity prolonged a month or more. I cannot subscribe to the plan of keeping every patient in bed for at least a month. In the last analysis, the period of bed-rest depends upon the duration and character of the activity of the lesion. There are some instances when activity will not subside so long as the patient leaves his bed for toilet necessities. The distance of the bath-room from the patient's bed may be a factor in continuing the activity in that the energy exerted in walking back and forth is the responsible cause. Absolute bed-rest, such as is practised in the acute stage of typhoid-fever, should be ordered far more frequently than it is our custom at present. I know that it is not feasible to have someone feed ward patients, but the cutting of the food often saves considerable of the patient's energy. Every now and then, some physician reports the temperature or pulse elevation or both subsiding after the patient is allowed to sit out of bed. My personal observation of such procedure has been, that for every patient benefitted, there are at least ten definitely injured by such treatment. Nothing can be more harmful than to disregard a rapid pulse in the cases running a normal temperature for it has been my observation that tachycardia calls for more rigid rest than a slight temperature.

One is often asked as to the proper treatment of hemorrhage or blood-spitting, so far as rest is concerned, and I feel that the *sine qua non* of therapy of this condition is rest. The patient should be propped up in bed in a semi-recumbent posture with a back-rest or pillows. The patient is not to sit up to expectorate and he should also observe vocal rest, for in that way cough is usually less troublesome. Absolute bed-rest and vocal rest should be practised for a period of a week after all bleeding has ceased and, in the case of repeated attacks of blood-spitting, this period should be doubled or quadrupled. During hemorrhage, there should be very little of an examination made and especially should percussion and auscultation with cough be avoided. It is quite noticeable at times that cough responds best to rest and the careful physician will not fail to employ vocal rest in addition to bed-rest where the cough has not subsided under the usual treatment. When hoarseness is present, vocal-rest should be the routine procedure, but it is surprising how often this instruction is omitted, even by laryngologists.

In the case of the patient who has been going to the bath-room for toilet necessities, the first exercise consists in sitting up on a reclining chair for fifteen or thirty minutes in the morning and increasing by a similar period every other day, the patient resting in bed alternate days. In other words, the patient remains in bed every other day except for the trips to the bath-room. The duration and severity of the activity determine whether to begin with a quarter or half-hour of exercise. After the patient is resting two hours out of bed, the periods can be increased by a half to an hour up to a full day of cure. This means that the patient continues to rest in bed every other day. Up to the limit of three hours of cure, all of the exercise should be taken in the forenoon. The next step is that the patient is permitted to remain out of bed all day for two days, resting in bed the third day. After a week this is followed by another week of taking cure for three successive days and resting in bed the fourth day. Next comes a period of four successive days of cure, followed by a fifth day of resting in bed. Now the patient is allowed to sit up all day for a week or more before beginning any definite walking exercise. One should bear in mind that at

times it is necessary to interrupt the exercise, whether sitting-up, walking or working. Evidences of renewed activity present themselves and the first manifestation should be an indication for caution. If the flare-up or a cold develops during the sitting-up period, the patient is to be returned to bed-rest at once, and if there is a return to the previous condition within a week, the progress can be by double up to the point of its discontinuation. If it is necessary to interrupt the walking exercise, rest on the chair in slight upsets, and rest in bed for the more severe manifestations should be the practice. It is never to be forgotten that frequent upsets during rest or exercise are of unfavorable prognostic import and the ordering of exercise for this type of patient is to be done with due regard for the slowness of increase of it. In some of this class, I have at times made increases of walking by one minute every day up to one hour and working exercise has been practised only every other day. On such patient is a woman who four years ago was too ill to continue her work in a training school for nurses but, during this time, she has spent about two years as a practical nurse. At present it looks as if she might make the goal, although I doubt if her finances will permit of cure now for the period necessary before it would be safe for her to complete the course in the training school for tuberculous nurses.

A measure which I have found very useful is that of resting one-half hour before and one hour after meals. During these periods, there is to be no talking, reading or writing, or any other effort, and the patient should assume a recumbent posture. his procedure is continued until exercise is indulged in for four hours when the periods of rest are gradually reduced as the exercise is increased. Depending upon the duration and severity of the activity, the patient begins walking exercise of one to five minutes in the morning and increases by one to five minutes every other day until he is walking one hour every other day, but the patient rests on his chair and bed the intervening day. Then follows a period of walking one hour on each of two successive days and resting on the third day. This is continued for seven or eight days, followed by walking for three days and resting on the fourth day for a similar duration of time. The patient

walks one hour for four days and, after a resting period on the fifth day, he walks one hour daily for seven days. During all of this time it is my custom to order walking to be very slow and all of it to be performed on level ground. When dealing with certain patients, the age, temperament, pulmonary damage and general physical condition will determine if the exercise is to be taken in one or several periods.

In some sanatoria walking exercise of an hour only is permitted and further increase of exercise consist of light or medium work. Personally, I prefer to have my patient walking three to four hours daily, before I consider them able to return to their former activities. In the case of the patient on prolonged walking exercise, the increase after the first hour is by five minutes daily up to two hours. This walking need not be done on level ground, but due regard should be paid to a down-grade during the last part of the exercise. After the two-hour point is reached, I prefer to make the increase by ten minutes every other day until the patient is walking three to four hours daily, this maximum amount of walking to be continued for a period of four weeks as a minimum before it is considered safe for the patient to resume his former occupation. This of course gives due regard to the character of the work at home. In the case of working exercise being the routine sanatorium measure, I am convinced that it should not replace at least one hour of walking exercise, but be given in addition to the latter. The work should be light in character in the beginning and the physician should be most careful to explain the need of working exercise in restoring the patient to an earning capacity. If undue emphasis is placed upon the quality of the work performed the patient soon begins to feel that his labors are employed in order to curtail expenses of management. Even though the work be poorly done, the energy expended by the patient in the time allotted for exercise should be the only basis upon which to work and unfavorable criticism of the quality of work usually defeats the therapeutic purpose of the exercise.

The first hour of working exercise should consist of light house work or those trades taught in occupational therapy classes, such as weaving raffia, reed-basketry, knitting, embroidering,

and the like. After the first hour of working exercise, the more severe tasks of field and garden work are to be employed, depending usually upon whether your patient was formerly accustomed or not to manual labor. The patient able to walk one hour daily without any upset, is now ordered one-half hour of light working exercise for a week and this is increased by a similar amount the following week. The next increase is by one-half to one hour weekly up to the point that the patient is working five to six hours daily in addition to one hour of walking exercise. This maximum amount of exercise is to be continued for four weeks as a minimum before it is safe to discharge the patient from the sanatorium. Even then, I feel that the patient on discharge, should be advised to do walking exercise at home for four weeks, beginning with one hour and increasing by one-quarter of an hour daily up to three or four hours before he resumes his former trade.

Due allowance should be made for individuals past mid-life or prematurely aged, for it would be folly to expect such persons to walk or work more than one-third to one-half the maximum period specified above. Also, there are many patients coming to us who are never to even reach the period of sitting-out of bed, while others are to be handicapped for life with a disability permitting of only rest out of bed. These points should be carefully remembered, for failure to observe them may shorten the lives of such persons.

My experience with children suffering from ulcerative pulmonary tuberculosis has been very limited and I am not prepared to discuss a scheme of exercise for such patients. Generally I have observed that these patients are acutely ill for a long time and comparatively few of them ever lose their activity. When we are with the pre-tuberculous child, it is important that strict rest in the chair or bed before and after meals is to be observed. The hours and character of play call for accurate supervision, while working exercise should be reserved for those past ten years of age and, even then, the character of work should be of the simplest.

Possibly Doc. Coue's effect on journalism is better shown in the A. P. dispatch from London, which says: "Day by day in every way the situation grows complicated and more complicated."

THE CLINICAL VALUE OF BLOOD CHEMISTRY*

By E. L. Shaffer, A.M., Ph.D.,

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One of the outstanding developments of modern researches along biological lines has been the adoption of quantitative methods of investigation. The principles of physics and chemistry have been more and more applied in the study of living matter, and have served to place such studies on a firm mathematical basis. This, I believe, is a healthy development, because it eliminates to a large extent the element of personal equation, gives us a concrete basis for comparisons and furthermore it is simple. When you can state a scientific observation in the form of a number you have a simple, direct expression readily analyzable and easily capable of comparison with other observations. This "quantitative viewpoint" has only begun to make its way into medicine, and the adoption of the principles of chemistry and physics will form a large part in the study of human disease in the future.

This evening I propose to speak concerning the value of chemical examination of the blood. This is a quantitative method applied to the study of disease. It should be our pride that the greatest researches along these lines have been recently made by American investigators, who have secured most accurate data and have devised methods of analysis that are at once simple and reliable. When we reflect that the blood is a highly complex fluid, containing substances of use to the body and others which are to be eliminated, we can see that any research bearing on the chemistry of the blood must be of far-reaching significance. We know that many of these substances are present in the blood in definite concentration in health, and these percentages are kept constant through action of the eliminative organs of the body, the skin, kidneys, lungs, etc. Or, as the results of faulty metabolism, certain of these substances pile up in the blood, the body being unable to utilize them. Consequently, any deviation from the normal percentages of these substances must be viewed as evidences of pathological conditions somewhere in the body, and moreover the percentages express *numerically* the degree of

*Read before the Mercer County Medical Society, December 13, 1922.

injury present. For instance, the greater the per cent. of blood sugar, the more severe is the diabetes, other things being equal. Therefore, simply from a prognostic point of view, blood chemistry is of value in determining the severity of disease present expressible in numbers, and gives us a better basis to judge the possibility or impossibility of recovery. Moreover, it serves to guide treatment, and by comparing tests we can determine whether a particular case is pursuing a favorable or unfavorable course.

First, I wish to consider the value of blood sugar estimations. Ordinarily the custom has been to diagnose diabetes mellitus by the presence of sugar in the urine. While such a routine examination should be employed at all times, yet the finding of sugar should not in every case establish the diagnosis. The differential diagnosis between temporary glycosuria, or "renal diabetes," and the true diabetes is the finding of an abnormally high blood sugar. As is well-known, glycosuria may exist without hyperglycemia and vice versa. Therefore, as a final court of appeal, the blood sugar should be estimated. Furthermore, in checking the results of a diabetic treatment, while the urine furnishes us with a rough estimate of progress, yet we cannot consider any case improved that does not show an improvement or reduction of the blood sugar.

It is the function of the kidneys to keep constant the concentration of the various substances in the blood. When these substances rise above the normal concentration, the kidneys excrete them in the urine. In other words, the kidneys are the chemical stabilizers of the body. The normal percentages of the blood chemical substances have been determined and the point beyond which they are excreted in the urine is called the "threshold point." For glucose, the threshold is between 0.16 per cent. and 0.18 per cent. When the blood sugar rises above this point sugar appears in the urine. However, this is not true in every case. In some individuals the point is lower (renal diabetes) and in others it is higher. Hence, in the latter group no sugar would appear in the urine, and yet the patient might be suffering from a marked hyperglycemia. This could only be solved by blood sugar estimation. These are usually the worst cases of diabetes, that is, those with a high sugar threshold, and examination of the urine gives no information as to the actual conditions.

The group of substances known as the

"blood retention products" are perhaps of the greatest practical importance. The most important of these are uric acid, urea and creatinine. Uric acid and urea are the end products of protein metabolism. Creatinine is a purely endogenous product (derived from the body substance) and is supposed to be formed chiefly in the muscles. The study of these substances is most important in the diagnosis and treatment of renal disease. Here again the routine examination of the urine, while useful, does not give reliable results, particularly in the early stages of nephritis. Of these products, uric acid is the first to make its appearance in abnormal percentage, then urea and finally creatinine. In other words, uric acid is the most difficult and creatinine the least difficult for the kidneys to eliminate.

The examination of the blood uric acid is important in distinguishing gout from arthritis, being high in the former and normal in the latter. Urea is in many ways the most important of these products, and its determination gives us a better indication of renal disease than perhaps any other test. The percentage of urea present may be taken as a direct measure of the extent of renal disease present. Therefore, its value in prognosis and as a guide to treatment can be readily seen. Creatinine, when present in abnormal concentration, indicates serious renal disease, since it is easiest for the kidneys to eliminate. Normally it is present in the concentration of 1 to 2 mgms. per 100 cc. blood, and when, after consistent treatment, it remains above 5 mgms., you can surely prognosticate an early fatality.

More and more is being shown the great value of these determinations in deciding the fitness of patients for urological surgery, particularly that of the prostate. The high mortality following prostatectomy is largely due to failure of the kidneys to function after operation, and the patients usually die of uremic poisoning. The surgeon, who is using blood chemical tests, together with function tests, will have a lower mortality than his confrere, who, seeing the prostatic indication for surgery, fails to look for contra-indications, such as blood chemistry might reveal. Other things being equal, the patient with normal retention products will stand a better chance than one with high percentages.

Blood chemistry has contributed much to our somewhat meagre understanding of the condition known as acidosis. Many of our ideas differ concerning acidosis, and

the name itself is somewhat misleading. The blood is never at any time during life even slightly acid; it is always slightly alkaline. Yet the kidneys secrete an acid urine from a relatively alkaline blood. This is done through the medium of the acid phosphates. The chief defenses of the blood against acidosis are: (1) The bicarbonates; (2) pulmonary ventilation, which gets rid of acid in the form of CO_2 ; (3) the proteins of the blood being amphoteric can combine with acid substances. Acidosis may be due to an increased production of acid substances, or to a decreased ability of the kidneys to eliminate these. The acidosis (ketosis) of diabetes is due to a faulty oxidation of fats, resulting in the formation of the acetone bodies. The acidosis of nephritis and of infantile diarrhea is probably due to a decreased ability of the kidneys to eliminate the acid phosphates. The test par excellence for determining the degree of acidosis is the determination of the CO_2 combining power of blood. The lower the combining power, the greater the acidosis. By CO_2 combining power we mean the ability of the blood to absorb CO_2 and throw it off by means of pulmonary ventilation. Increased pulmonary ventilation or hypernoea is, therefore, a useful reaction of the organism and should be taken as one of the best physical signs of acidosis and an indication for alkaline therapy.

I have spoken concerning the more important blood chemical substances and their relation to certain metabolic disorders and renal disease. While the practical application of these tests seems to be limited to relatively few diseases, yet I believe the application of these principles in the study of other human diseases will yield important results and throw more light on the nature of disease in general. Much patient study and research will be necessary before we can come to any practical conclusions. The present day blood chemistry has been evolved through many years of such study. It has been made practical; the methods have been simplified; the results are truly quantitative, and this evening I have attempted to point out its general usefulness. It should form a part of our routine laboratory examinations, as much as blood counts, Wassermanns and urine examinations.

IMPOTENTIA COEUNDI, DUE TO PATHOLOGIC CHANGES IN THE POSTERIOR URETHRA.

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The treatment of male impotence has always been a crux for the physician. True, one was always clear about the importance of this affliction and realized the depressions suffered by these patients, but to relieve them was not always an easy matter, and we know that only rarely does such a patient improve without treatment. It is also common knowledge that "suggestive treatment" of patients suffering entirely from psychic complaints is difficult to carry out and requires a great deal of valuable time, because every statement or word of encouragement must be carefully weighed, since in their hysteric frame of mind these patients usually misinterpret and become possessed of the most unbelievable ideas. For those reasons, the treatment of such unfortunate patients is sometimes neglected. A large number do not receive proper examinations or treatment. In many cases impotence is not "functional," but is based upon real organic changes. Just as the treatment causes no happiness in the psychically sick patient, great relief and satisfaction is brought to this small group, who are suffering from organic disease.

In order to accomplish good results in the treatment of impotence, due to organic disease, it is absolutely necessary to select the individual patients. Not only is it essential to obtain a complete previous history of the patient for diligent study, but also a posterior urethroscopy must be performed. All other methods are very uncertain. Such an examination and study exclude at once all patients who show unmistakable signs of psychic impotence, i. e., those who believe their genitals are weak and undeveloped, or those, who, because of long abstinence, are temporarily impotent, and those who do hard, especially, brain work, and, therefore, are not able to perform their sexual functions normally. Furthermore, all those who are suffering from fear of being suddenly surprised or detected, others who are sexual deficient from fear of venereal

disease, or from fear of their incapability of satisfying the partner and many similar hindrances known to every physician in a large variety of forms, but which it is not necessary to cite here, are excluded. All these instances can be influenced by "suggestive treatment," as well as therapeutically, with electric currents, aphrodisiaca, etc. Co-operation between specialists in urology and nervous diseases brings the best results. In this paper I merely wish to speak of instances caused by organic changes. These relate mainly to changes in the colliculus seminalis.

The microscopic examination of the secretions of the posterior urethra gives us only little information concerning the diseased changes in the colliculus, it shows only that somewhere in the posterior urethra a diseased condition exists, but it does not tell us where. Better than a microscopic examination is an exploration with an olive-pointed sound or probe, which makes it possible, after a little experience, to feel if the colliculus, which is mainly concerned, is diseased or not. In normal conditions we usually do not feel the colliculus during such an examination, but where an enlarged and diseased colliculus exists, it is easily felt. The increased complaints and pain from which some patients suffer, when this point is touched, is not typical of diseased changes. They may be due to nothing more than the patient's over-sensitiveness, as has been often demonstrated by the urethroscope.

According to the above, it becomes clear that it is impossible to make a positive diagnosis without a proper examination of the posterior urethra. The urethroscopy shows us, with complete clearness, all stages of changes in the colliculus. While the normal colliculus is easily found, through the urethroscope, and appears as a small, light red uvula-like elevation, pyramid-shaped, with the base downward, pointing into the lumen of the urethroscope, the finding of the swollen colliculus often produces difficulties. The swelling or enlargement, which is the most frequent sign of disease, can be of such nature as to cover up the entire lumen of the urethroscopic tube. In such cases it is necessary to manipulate the instrument forward and backward in order to first find the edge of the colliculus, when it can be observed that the surface has

no more the polished, even appearance of the normal organ, but is strongly congested, edematous, uneven, rough, etc. In advanced cases the congestion disappears and the mucous membrane becomes pale and atrophic in appearance. In these stages, one can see the openings of the ductus prostatici much plainer than in the beginning stages. They appear as gaping, deep red openings on a pale surface. Much less frequently one sees ulcers on the colliculus. Almost always, in such conditions, the colliculus is increased in size and shows many thin, mucous threads, which float freely when the canal is irrigated. A true ulcer, with a pusy basis, is rarely seen.

Frequent disease changes of the colliculus, as well as in the neighboring mucous membrane, are the growth of polypi. A large variety can be seen, consisting either of one polyp, with its entire size and base easily visible and removable, to numerous polypi of larger and smaller dimensions and with thicker bases, which cannot easily be removed through the endoscope and whose treatment is apt to cause difficulties. The color of the pathologic changes is apt to be influenced in several ways and, therefore, cannot always be depended upon as an aid in diagnosis. Disturbances of circulation and hyperemia are apt to effect the color; the method of introducing the urethroscope and its consequent irritation causes a difference in appearance; if one uses too much or too little illumination during the examination the color changes accordingly. Granulations formed upon the colliculus, which are more or less always the result of chronic diseases, appear as nodule formations of various sizes. They merely serve for diagnostic purposes and it does not seem advisable to attempt to influence them therapeutically. Though treatment sometimes improves the condition temporarily, they are usually very resistant to treatment, and cauterization occasionally causes the development of epididymitis. Weaker cauterizations, with 5 per cent. solutions of argentum nitricum, are apt to give better results, without causing any complications.

The above are, briefly stated, the most frequent changes observed. As etiological factors, various diseases come into question. In the first place comes chronic gonorrhea and chronic inflammation of the prostate resulting from a

previous gonorrhea. Less frequent sources are diseases of the posterior urethra caused by staphylococci, streptococci, bact. coli., etc. These bacteria only seldom produce inflammations severe enough to result in diseased changes. More often than is perhaps believed, the tubercle bacillus is the cause. A descending tuberculosis of the bladder and posterior urethra is not to be entirely ignored. More frequently than those infectious diseases, sexual excesses are apt to be the cause. Excessive masturbation carried on for a number of years, a prolonged practice of coitus interruptus and protracted coitus are prominent causes, especially in patients who suffer frequently repeated and continual irritations, causing repeated congestions in the posterior urethra and, later, in the colliculus. Patients who suffer from impotencia coeundi, due to pathologic changes in the colliculus or surrounding mucous membrane, show special kinds of impotence, i. e., they suffer from ejaculatio praecox or from insufficient erections. Complete inability of erections occur only in the late stages. Whereas, those suffering from psychic impotence complain of complete absence of erections from the beginning.

As pointed out already, a complete and painstaking history gives us certain fundamental information. It is, however, very dangerous to rely too much upon the history alone, which can usually be influenced by the questioner, as well as by the methods employed in questioning the patient. A posterior urethroscopy, properly performed is the only reliable means to make a positive diagnosis. It must not be assumed, however, that the diagnosis, whether the colliculus has undergone changes, whether it is enlarged, etc., is always easy. Furthermore, the accuracy of the diagnosis depends largely upon the experience of the examiner and the speed with which the examination is executed. An inexperienced examiner can easily cause hemorrhage during the introduction of the instrument, causing the field of vision to be darkened and to give the appearance of pathologic conditions. An enlarged colliculus is all too frequently diagnosed, caused mainly by a faulty maneuvering of the optic, when no really pathologic condition exists. It is, therefore, to be recommended that a be-

ginner always examines the colliculus with the some optic and with the optic in the same position. Concerning the technique of urethroscopy, I refer the readers to the standard works upon the subject of Goldschmidt, Wossidlo, Schlenzka and others.

For the treatment of impotence caused by changes in the colliculus, we must first consider local cauterizations, with 10-20 per cent. argent nitric. Only when local cauterization gives no results, has the writer resorted to galvanocautic application, which are not always easy to execute. For the destruction of polypi, galvanocautic applications usually give the desired results. Some workers in this field praise the small curette for this purpose. Naturally one must not forget the general treatment in such cases. The damage caused by these pathologic changes must receive proper attention, aside from the attempt to remove the damage already caused. Hygienic and dietitic rules should play an important role. Unpleasant complications resulting from local treatment, when proper use of the necessary instrumentation is made, occur only very seldom. Aside from slight hemorrhages, the development of epididymitis alone should be feared. The development of this complication is unpleasant, though usually of a mild type and disappears rapidly. The resultant effect from the treatment is often very striking. Frequently only one treatment is necessary for the patient to be able to perform his normal sexual functions satisfactorily. Such patients should not be cauterized further. Some patients improve slowly and gradually, their potency becoming gradually stronger, after several cauterizations have been made. Yet, aside from the most careful selection of patients, there always remain some who do not react to this treatment. With them, the psychic hindrances are too strong and are constantly growing stronger to be offset by local treatment. Such patients cannot be cured through local treatment, they may even get worse, and their neurasthenia even increased.

Summarizing briefly what has already been stated, we see that the impotentia coeundi, caused by pathologic changes in the colliculus, can usually be properly and successfully influenced by local treatment. Of the sum total of patients

suffering from impotence, they constitute but a small percentage. Care should be given in selecting the cases for local cauterization, in order not to increase the neurasthenia of those who may not react to it. Above all, a proper diagnosis of the true changes in the colliculus should be made first, by means of the posterior urethroscope. Only in that way can we accomplish good results and avoid causing additional patients to suffer from sexual neurasthenia, when they have not suffered from this depressing symptom heretofore, or only slightly. With the proper methods, we can select out of the great number of the impotent, a few for whom this treatment is especially designed, and it will be possible to free them from their life-long suffering.

County Medical Societies' Reports

CAMDEN COUNTY

Testimonial Dinner to Dr. Strock

A testimonial dinner was given to Dr. Daniel Strock, of Camden, by the Camden County Medical Society, at the Mohican Club, May 9, in honor of his faithful service of thirty-four years as secretary, which position he recently resigned. There was a large attendance of members and their wives and doctors from adjoining counties. A splendid dinner was served, after which Dr. Thomas B. Lee, acting as toastmaster, introduced as speakers President Hunter, of the State Medical Society, Dr. D. C. English, editor of the State Society Journal, and Dr. W. A. Wescott, who made congratulatory addresses. Then Dr. E. B. Rogers, recalling Dr. Strock's services to the county and State societies and the public, presented him a splendid gold desk clock. Dr. Strock responded eloquently in accepting the society's gift.

CUMBERLAND COUNTY.

E. S. Corson, M. D., Reporter.

Annual Report.—The society has maintained its standard in attendance and scientific work during the past year. We are lacking in our reciprocal relations with neighboring societies. This may be due to the lack of attention of the visiting delegates to their places on the committee. Especially is it due to ignorance of the time and place of the meetings. Then again, when they do attend they do not manifest sufficient interest to give an enlightening report of the program. A short, snappy report would give the gist of the meeting and add an important item to our program. The meetings are too short to admit of case reports, which, to a great extent, are wholly neglected. The visits of the District Councilor, Dr. W. P. Conway, have been very helpful. He has informed us of the work of the State Council and the component societies. The close proximity of the State meeting should bring a full attendance from our

society. Our finances are in good condition and the increased membership fee has not proved detrimental.

GLOUCESTER COUNTY.

Henry B. Diverty, M. D., Reporter.

The Gloucester County Society met May 25 at Atlantic City, the guests of Dr. Madeleine A. Hallowell. There was a good attendance of members with their wives and also Dr. Richardson from Camden, Dr. Miller and wife from Millville, Dr. Husted and wife from Salem, and Dr. D. C. English from New Brunswick. Two new members were elected: Drs. Oran A. Wood of Paulsboro and H. B. Walker of Newfield.

After a short business session the balance of time was given to Dr. Hallowell, who spoke of her work and it was conclusively shown that she was getting wonderfully good results in caring for the mentally and physically defective children. Then followed one of the most substantial lunches we have ever had. The society is certainly much indebted to Dr. Hallowell.

MERCER COUNTY.

A. Dunbar Hutchinson, M. D., Reporter

The Mercer County Society has held several very interesting meetings during the past five months.

The January Meeting was one of the most entertaining, and also largely attended. Several applications were received and referred to the membership committee. Dr. John W. Churchman of the Loomis Laboratory, Cornell University, N. Y., was the principal speaker of the evening. His subject was "Selective Bacteriostatic Power of Aniline Dyes," the address being supplemented by a series of slides, showing the adaptability of such dyes in the Bacteriological Laboratory. This address aside from the interesting point of view, was highly instructive, and was greatly appreciated by a very enthusiastic audience.

Owing to the meeting of several organizations in Trenton, during the month of February no regular meeting was held of the Society.

In March, Dr. W. Henley Smith, of Trenton, gave a thorough account of the procedure in "The Phenol Tetrachlorophthalein test for Hepatic Function." Dr. Smith was not only entertaining but was quite ready to explain and enlighten the several members that were courageous enough to discuss the paper.

Dr. Wm. Sharpe of the Polyclinic Hospital, N. Y., was the speaker of prominence at the meeting in April. His subject, "Recent Progress in Neurologic Surgery," brought to light many instructive points, and developed one of the most entertaining discussions that this Society has ever enjoyed. In the course of his address he described the surgery pertaining to Brain Injuries, Paralysis following injury to the Brachial Plexus, Hydrocephalus and Injuries in Parturition. Several very interesting cases were cited with comprehensive data, in the different phases above mentioned, thus adding much to the able address.

The May meeting was held at the State Hospital, and was enlivened by the presence of many members of the State Dental Society, guests of Dr. Cotton.

Dr. Julius A. Toren of Chicago, addressed the society on the subject of "Diagnosis of Oral Infection by Blood Examination." He drew particular attention to the fact that the experience gained in his work in Chicago, had led him to form a definite conclusion regarding the finding and isolating, staining and identifying of a cell in the body fluid, to be found only in Oral Infection.

Many beautiful slides, all hand colored and thus requiring a special machine, (which our society was able to acquire, for use that evening) were shown, and explained by Dr. Toren. Many of the points made by Dr. Toren were taken exception to by several of the Dental men, and a very thorough discussion followed, Dr. Toren in every instance making himself clear.

Dr. Cotton had arranged a very interesting display of Xray and other pictures, all pertaining to this line of work.

MONMOUTH COUNTY

D. M. P. Magee, M. D., Reporter.

During March, April and May the Monmouth County Medical Society has not by any means been inactive, even though no data has appeared in the Journal. In each one of these months the society held a very interesting and instructive meeting, and the attendance has averaged fully forty per cent., with the interest in the subjects discussed and papers read being very keen.

At the March meeting we had a paper on the "Special Indications for Digitalis and Quinidine in Heart Disease." This paper was read by Dr. H. E. B. Pardee, of New York. At the April meeting the Society was very much interested in a talk given by Dr. V. V. Anderson on the "Establishment of Mental Hygiene Clinics in Monmouth County." This was particularly interesting to the society, in view of the fact that during the past several years Monmouth County seems to have been picked for the establishment of various welfare clinics, etc., with their accompanying social service work. Also at this meeting there was a very interesting discussion of several rather unusual medical and surgical cases that some of the physicians had encountered. At the May meeting a very excellent paper was read by Dr. Frederick Bancroft on the subject "Cholecystitis."

It would probably be safe to say that at no time in the history of the Monmouth County Medical Society has the attendance at meetings and the interest and enthusiasm shown approached anything like what we have been during this present year.

SALEM COUNTY.

William H. James, M. D., Reporter.

The regular meeting of the Salem County Medical Society was held in the sun parlors of the Memorial Hospital, April 11, at 2 p. m. The meeting was called to order by the president, Dr. C. W. Thomas.

The members of the society and delegates from the neighboring societies had the pleasure of listening to Dr. C. C. Beling, a neurologist, from Newark. To those who have heard Dr. Beling he needs no introduction. For when once you have listened to his lec-

ture you are thoroughly impressed with his intelligent and scientific way of expressing his views. He selected for his topic "The Good in All Pathies." After the conclusion of his talk, the society gave him a rising vote of thanks.

Dr. Walt P. Conoway, of Atlantic City, councilor of the Fifth district, was present and gave an interesting talk on the advantages of being protected against malpractice suits, as physicians and surgeons are now being prosecuted for the most trivial causes.

Dr. James Hunter, Jr., president of the New Jersey State Medical Society, was present and took part in some of the discussions. The visiting physicians were: From Gloucester County, Drs. Ashcraft, Downs and Hunter; from Cumberland, Drs. Glendon Lyon and Simpkin; from Essex, Dr. Beling; from Atlantic, Dr. Conway. The regular members present were: Drs. Sherron, Davis, Church, Hummel, Ewen, Hilliard, Green and Hires, of Salem; Drs. Husted, DeGroff and Thomas, of Woodstown; Dr. Good of Alloway; Drs. Bramble and Davies, of Elmer; Dr. Summerill, of Pennsgrove, and Dr. James, of Pennsville.

Local Medical Societies

BARNERT HOSPITAL CLINICAL SOCIETY

A. Shulman, M. D., Secretary.

The thirtieth regular meeting of the Barnert Hospital Clinical Society was held at the hospital on March 20, 1923.

Dr. Spickers presented the case of a girl, aged sixteen, admitted on January 26, 1923. The history was difficult to obtain, as the girl is a moron. She had had, two months before admission, a cold, with pain in the chest. There were no other symptoms. On admission, she complained chiefly of fever. Empyemia was found. The seventh rib was resected, under local anaesthesia. Much pus was evacuated by suction. After the drainage tube was removed at the usual time, the temperature became septic in character. Xray showed a fluid level. The wound was then reopened and the chest irrigated with Dakin's solution. Six weeks after admission, the same rib was resected more anteriorly. The patient still continues her febrile course, two months after admission. She is markedly emaciated. There is no sign of subdiaphragmatic abscess. Culture of the pus was sterile. Probably the cause of her continued fever is the thick, fibrinous, purulent membrane covering the collapsed lung. Further treatment is a problem. Radical operation seems too dangerous.

Dr. Roemer thought, since the patient entered with a spontaneous pyopneumothorax, that the underlying cause of the condition was tuberculosis, which cannot be demonstrated in the collapsed lung. Dr. Piller said that aspiration, with suction (Potain), would have been better treatment than rib resection. He stated that Dr. Alfred Meyer, of New York, gets good results in such cases by potaining, and then injecting nitrogen through the same needle.

Dr. Curtis reported the case of a boy, aged nine, who was admitted in a comatose con-

dition. He had had measles, pertussis and epilepsy. For the latter, circumcision and adenoidectomy had been done some time before. The symptoms were relieved for several months. One day before admission, he had had a headache and convulsion, followed by a sound sleep, apparently a post-epileptic coma. This, however, did not clear up. The temperature was normal. The neck became rigid. There were involuntary twitchings of the facial muscles. Lumbar puncture showed no abnormalities beyond increase in pressure. The urine (catheterized) showed a marked albumin reaction, and numerous casts. On admission, the temperature was 100 degrees; the next day, 104 degrees. In spite of stimulation, the boy died within twenty-four hours. The diagnosis was probably uremia. A Wassermann, done before the present illness, was negative.

Dr. Plant thought that the case might have been one of coma epilepticum, rather than uremia.

Dr. Shulman presented the case of a primipara, aged twenty-four, admitted on February 13, 1923, in labor. Pelvic measurements and urine were normal. Examination showed a cervix, admitting one finger, with ruptured membranes and occiput presentation. After eighteen hours of labor there was no further dilatation. Morphine sulphat, gr. $\frac{1}{4}$, was given. This gave the patient some rest for about six hours, after which she was allowed to remain in active labor for another eighteen hours, pains occurring every three to eight minutes, and last about thirty seconds. At the end of this time, the cervix admitted two fingers. Morphine was again given, but gave no relief. About six hours later the pulse rate went up to 120, and became slightly weaker. Immediate delivery was considered advisable. Accouchement force by the method of Dr. P. A. Harris was undertaken. Dilatation of the vagina and cervix took about one hour.

Axis-traction forceps were then applied to the head in mid-pelvis in R. O. P. position. Reliery was finally effected in thirty-five minutes, in the persistent posterior position. A moderate second-degree laceration resulted. The baby's forehead sustained slight laceration, just lateral to the left eye. There was also a right facial palsy, which cleared up in twenty-four hours. The laceration constantly oozed until the baby's death. At thirty-six hours, paralysis of the left arm occurred, followed by generalized muscular twitchings and convulsions. The baby died fifty-six hours after birth. Except for vesical spasm, followed by incontinence for three or four weeks, the mother's convalescence was uneventful. It was suggested that the cerebral hemorrhage, causing the baby's death might have been of the melena neovatorium type. The only evidence of this was the constant oozing from the facial laceration. Dr. Spickers agreed that the handling of the case was correct. He thought that the use of a champetier ribes bag might have helped to secure dilatation.

Dr. Winters reported the case of a woman, aged twenty-four, who, after a cold, developed the following symptoms: Fever, headache diplopia, restlessness and irritabil-

ity. Examination showed a mild Kering sign, unequal pupils, which did not react to light, and negative eye-grounds. The temperature ranged from 100 to 102 degrees. In spite of sedatives, the restlessness increased, and the patient died, four days after admission. The diagnosis was encephalitis.

Dr. Roemer discussed the difference between encephalitis of the epidemic type and that due to focal infection. The first was characterized by lethargy, the latter by restlessness and irritability. Dr. Plant explained this by the statement that the difference was in the pathology—the lethargic cases showed lesions in the candate and lentiform muscles.

During the collation, Dr. Winters gave a short lecture on "The Life and Work of Edward Jenner." He told of Jenner's difficulties in having his theories accepted, of his sacrifices, of his final success and of his recognition by the king.

BAYONNE MEDICAL SOCIETY

M. I. Marshak, M. D., Reporter.

The Bayonne Medical Society met at the Elks' Club on March 19, 1923. Dr. F. M. Dearborn, professor of dermatology at the New York Homeopathic Medical College, was the speaker of the evening. He spoke on "Common Dermatological Errors." He brought out eleven special points:

1. In the treatment of ring-worm of the body iodine used by itself is a waste of time. Ring-worm, as well as all fungi, are best treated by the exclusion of oxygen. Therefore, collodian should be used daily. Five per cent. of iodine in collodian is the mixture recommended. The iodine being used in memory of old ideas.

2. Many skin conditions are called scabies, pediculosis corporis being the one most frequently mistaken. Lanolin is the only base of any use in the treatment of scabies. A hot bath, followed by the use of a 30 per cent. sulphur in lanolin ointment, should cause the scabies to clear up in from four to six days. Sulphur vapor baths are also of value, and are used extensively in France.

3. Eczema has marked subjective sensations, there occurs the formation of patches, which clear from the border. If the lesions are old, moisture is formed. It is spread by scratching, showing that it is autoinoculable. Irritants must be present to produce eczema. Patients developing eczema have a catarrh tendency and eczema is a catarrh of the skin. The treatment is as much constitutional as it is local.

4. Psoriasis is essentially a neurosis of diathetic origin. There is no proof of any parasitic cause. It is affected by climate and usually clears up in the spring of the year. It calls for internal as well as external treatment. The neurotic element is pronounced.

5. Pityriasis Rosae is always associated with anemia. The treatment should be tonic. Eruption clears up in from two to three weeks.

6. The leprosy as seen here is of the macular anesthetic type and is not contagious. The tubercular and ulcerative or contagious type is rarely seen here. There is a possi-

bility that the disease is modified by the climate.

7. Lupus Vulgarus is one of the four forms of tuberculosis of the skin, and is best treated by the Finsen light.

8. Lupus Erythematosus is a para tuberculide and bears the same relation to tuberculosis as the para syphilitic lesions have to syphilis. There is little response to treatment, the best results are obtained by treating it as a disease of internal origin. Locally freezing and fulguration can be used only on small lesions.

9. Acne is an explosion of the oil glands, with the inability of discharging the excess oil, because of plugging of the pores. Never use ointments or manipulation or alternate hot and cold water. Don't allow the use of powders, creams or greases. Don't allow the patients to remove blackheads, remove them yourself. Encourage the use of cold water applications, best as sudden douche. Soap is an irritant, and should be used for cleansing purposes only. Use elbow grease with a towel. Astringent lotions, as Lotio Carbonas, Detergens 5 per cent., or a lotion of glycerine and milk of magnesia, are of value, combined with nuxvomica internally.

10. Rosacea, or rum blossom, bears no relation to the use of rum. It calls for supportive treatment in the form of rest, some local astringent and improvement in circulation and the diet. It is due to varicose veins.

11. Multiple fibromata are usually associated with fibromata of the uterus. Forty out of forty-eight cases of fibromata of the uterus showed fibromata of the skin.

Discussion by Dr. Shapiro. Chrysarobin, covered with collodian, has been used in the treatment of ring-worm of the body. An ointment of beta-naphthol, chalk and green soap is more effective in the treatment of scabies than is sulphur. That psoriasis clears up in the spring is probably due to the effect of the sun rays on the skin. The ultra-violet ray at times gives good results in treatment. Constitutional treatment is of importance. Psoriasis is due to some unbalancing of the nitrogen partition and shows an increase of the nitrogen products in the blood and urine. In pityriasis rosae the finding of the mother spot is important in diagnosis. Lupus vulgarus is always unilateral, except if it is a direct continuation of the original spot. If lupus erythematosus is of tuberculous origin, why cannot we use tuberculin in its treatment? In acne, why not keep the pores open, so that they can excrete more freely? If not of bacterial origin why do autogenous vaccines give good results at times?

Dr. Dearborn: "Vaccines are only effective if other organisms besides the acne bacillus are present." In answer to a question: "Psoriasis is at times thought to be caused by a hypo-function of the thymus gland. After an extensive experience with the receiving an xray burn, I do not use the xray in the treatment of skin diseases, except in the case of cancer."

Hoboken Medical Society

A regular meeting was held at the Union Club, April 17. After routine business, the following cases were reported: Dr. Spath,

two cases of severe pneumonia successfully treated by use of diathermy; Dr. Diehm, a case of downward dislocation of the uterus due to improper application of forceps.

Dr. Vander Veer then gave an instructive lecture on "Diagnosis and Treatment of Hay Fever and Asthma." He reported 78 per cent. marked benefit by the proper use of pollen extracts. The commercial extracts contain only about half the nitrogen content of the New York Hospital product. The use of adrenalin for constitutional reactions was emphasized. The difficulty of diagnosis was also emphasized.

Jersey City Practitioners' Club.

The regular meeting was held April 10. The following officers were elected: President, H. T. VonDeesten; vice-president, F. J. Quigley; secretary, H. S. Forman; executive committee, Drs. Chambers, Spence and Sexsmith.

Dr. Quigley reported a case of malignant pustule in an Italian woolworker. The pustule back of left ear. He was cured by injections of anthrax serum. Dr. W. Pyle reported a case of pneumonia treated with diathermic electric current promptly recovering after four treatments. Dr. Cosgrove reported a case of complete separation of a normally implanted placenta before labor. Woman in profound shock. Patient transfused, delivered and recovered. Dr. I. Pyle reported a case of spontaneous pneumothorax, occurring at a dance, severe pain and dyspnoea.

Dr. Steadman reported a case of prolapse of the cord, the cord being stretched over the vertex of the child, delivered by section with a living child.

The paper of the evening was then read by Dr. Axford, his subject being "Xray Treatment of Hypertrophied Prostate." After an experience of some thirty cases, he was impressed with its success. He attributed this to the action of the ray on the testicles, which was his method. The ray caused a sterilization of the subject and then indirectly an effect on the prostate to cause its diminution in size. The paper was discussed by Drs. Woodruff, Rector, Miner and Bortone.

SUMMIT MEDICAL SOCIETY.

William J. Lamson, M. D., Secretary.

The annual meeting was held at the Canoe Brook Country Club May 25, Dr. Moister presiding and Dr. English entertaining, with a good attendance.

Dr. W. H. Lawrence was elected president, Dr. D. E. English, vice-president, and Dr. W. J. Lamson, secretary. Dr. English read the paper of the evening, on "Dietetics." He disapproved the usual method of feeding infants and favored what he termed "natural feeding," based on his forty years' experience. He emphasized the fact that too much food is eaten and urged decreasing the amount of meat in the diet after forty and total abstinence of meat after forty-five years.

We are compelled to defer insertion of other local reports because of late arrivals of matter that it was necessary to insert, especially the announcements and program of our annual meeting.

THE JOURNAL

OF THE

Medical Society of New Jersey

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PUBLICATION COMMITTEE:

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New Brunswick.

Each member of the State Society is entitled to receive a copy of the JOURNAL every month.

Any member failing to receive the paper will confer a favor by notifying the Publication Committee of the fact.

NOTE.—The transaction of business will be expedited, and prompt attention secured if,—

All papers, news items, reports for publication and any matters of medical or scientific interest, are sent direct to THE EDITOR, New Brunswick.

All communications relating to reprints, subscriptions, changes of address, extra copies of the JOURNAL books for review, advertisements, or any matter pertaining to the business management of the JOURNAL are sent direct to THE CHAIRMAN OF THE PUBLICATION COMMITTEE, Newark

157th ANNUAL MEETING OF THE

Medical Society of New Jersey

HADDON HALL, ATLANTIC CITY

June 21st to 23rd, 1923

(See Pages 209-211.)

The Board of Trustees will meet in Haddon Hall, Wednesday evening, June 20th, at 8 o'clock.

Attention is called to the change made in the by-laws last year, requiring each county society to elect its representative who shall serve on the Nominating Committee of the State Society. If any society has thus far failed to do so, it should act at once.

We correct the statement made in the May Journal that a copy of the annual meeting program would be sent to the members of the society. Instead of doing so we print it and the announcements in full in this issue of the Journal, pages 209-211, and ask our members to give them careful reading, especially those who expect to attend. A finely illustrated souvenir program will be presented to each permanent, annual and associate delegate when registering.

If any county society secretary has not

yet informed Dr. Chandler who the delegates from his society to the State society are, he should do so at once.

THE OFFICIAL LIST.

The Official List, prepared by the Secretary of the State Society, assisted by the secretaries and treasurers of the county societies, is issued with this month's Journal, as a supplement, as ordered by the State society, but it is not in any way under the supervision of the editor or Publication Committee. The editor, however, calls attention to a few of the mistakes in the list that should be corrected in order to avoid questioning and loss of time at the annual meeting. Dr. H. B. Costill's name should be added to the list of Fellows, not of Honorary Members. Dr. W. J. Carrington is corresponding, not recording secretary. To the list of Trustees should be added the names of Drs. J. Minor Maghee, B. S. Pollak, G. N. J. Sommer, P. M. Mecray and J. H. Underwood. Dr. Mefford Runyon is Councilor of the First District and Dr. Henry Spence of the Second District, instead of Drs. Beling and McCoy, respectively. The correct list is given on page 216.

If the names of any members who have paid their 1923 dues are not in the Official List, or are in with incorrect residence, they will please inform Dr. Bennett, chairman of the Publication Committee, at once, that he may get the mailing list correct.

ANNUAL MEETING "DON'TS."

Don't fail to attend if you have been elected a delegate. You were elected to represent your county society.

Don't fail to engage your room at Haddon Hall as soon as you have decided to attend, and if you have not done so—

Don't blame the hotel authorities if you don't get the room you desire. They wish to do the best they can in providing for our comfort and pleasure. It is impossible if two or three hundred unexpected guests arrive at the last moment.

Don't fail to register at the Credential Committee's office and get your badge as early as possible after your arrival at the hotel. See announcements elsewhere.

Don't fail to attend all the sessions. Sight-seeing or even golf playing during the sessions is not paying full respect to those who favor us with addresses or papers.

Don't fail to visit our exhibitors' quarters and to make purchases of articles they offer and you may need. Care has been taken in admitting exhibitors whose goods are ethical and of best quality.

Don't go home forgetting what you have seen and heard that would make you better practitioners and better men in the service of humanity, and

Don't fail to report to your county society what was done that ought to make your fellow members of more worth to the profession and the public.

DESERVING PRAISE

In calling our members special attention to the announcements and program given on pages 210-212, we commend the work of our State Society's Committee on Program and Arrangements, Dr. M. W. Reddan, chairman. Never has there been more careful thought and planning for our annual meeting than has been given this year. It has been done at much sacrifice on the part of the members of the committee and especially of its secretary, Dr. W. D. Olmstead, who arranged the details of the program. We are expecting to have the largest and one of the best annual meetings this year we have ever held and it will be due largely to the work of this committee and of our president, Dr. James Hunter, Jr.

GOLFERS, ATTENTION!

The golf tournament that is usually run during the annual meeting will be held at one of the sporty Atlantic City courses on Friday, June 22, 1923. Special prizes for low gross and low net, both morning and afternoon, and the regular prizes will be given. You register for play and get all information at the Committee of Arrangements' desk in the exhibit hall, ground floor exchange, Haddon Hall, at any time. Drs. John Clayton and Charles J. Sullivan will be in charge. All golfers should come prepared to play.

Miscellaneous Items

New Jersey State Pediatric Society.

This society will hold its annual meeting in Haddon Hall, Atlantic City, Wednesday evening, June 20, at eight o'clock. President E. W. Murray will deliver an address and papers will be read by Dr. La Fetra, of New York, on "Simplified Methods of Infant Feeding," and Dr. Stetson, on "Blood Transfusion in Children."

National Conference on Social Work.—In the conference held in Washington, D. C., last

month, Dr. Livingston Farrand emphasized the increasing importance of health as a link in the solution of social and economic problems. He predicted that the ultimate significance of social and economic conditions to the physical and mental welfare of the race would be realized with development of health and disease control "which will utilize to the full significant relationship which economic conditions and general family welfare bear to health."

Periodical medical examination of all individuals was urged by Dr. Hermann M. Biggs, State Health Commissioner of New York, in the effort to lengthen lives. He also advocated "systematic instruction in health in all schools and universities and the inculcation of health habits" with continuation of the campaign of health education by public authorities and voluntary agencies.

American Proctologic Society

The twenty-fourth meeting will be held in Hotel Alexandria, Los Angeles, Cal., June 22 and 23, 1923. Clinics will be held in the Los Angeles County Hospital. The presidential address will be delivered by Rr. Emmet H. Terrell, of Richmond, Va. Among the thirteen papers and case reports there will be a paper by Dr. Joseph M. Mathews, of Seattle, Wash., entitled "A Plea for the Protection of Young Wives Against Venereal Disease," and one on "Cancer," by Dr. J. R. Pennington, of Chicago, Ill.

Chair of Nursing Endowed at Columbia.

Through the foundation of a chair of nursing by Mrs. Helen Hartley Jenkins, of New York, Miss Adelaide Nutting has been made professor of nursing at Teachers' College, Columbia University. This is reported to be the first endowment of its kind.

Newark Health Exposition.

This exposition will be in the Sussex Avenue Armory, Newark, June 4 to 9. "The Route to Perfect Health," which is to show in graphic form the fight made against tuberculosis, employing a toy train to run from "station to station," will feature the tuberculosis exhibit. Dr. M. J. Fine, director of the division of tuberculosis of the local Health Department, is chairman of the committee in charge of the exhibit. He will have the co-operation of Dr. Samuel B. English, superintendent of the State Sanatorium at Glen Gardner; Mrs. Elizabeth A. Harris, chairman of the Freeholders' Essex Mountain Sanatorium Committee; Freeholder Philip Lindeman, representing the Jewish Anti-Tuberculosis League; Jacob C. Taylor, of the Trades Union Anti-Tuberculosis Association; Miss Beulah A. Bain, of the Montclair Board of Health; Dr. Ralph H. Hunt, of the Anti-Tuberculosis League of the Oranges; Ernest Easton, of the New Jersey Tuberculosis League.

We regret to hear as the Journal goes to press that Dr. G. W. Endicott, Plainfield's oldest practicing physician, died May 31st. Further notice in next month's Journal.

**ONE HUNDRED AND FIFTY-SEVENTH
ANNUAL MEETING
OF THE
MEDICAL SOCIETY OF NEW JERSEY
AT HADDON HALL,
ATLANTIC CITY, JUNE 21-23, 1923
ANNOUNCEMENTS**

The Committee on Credentials will meet at Haddon Hall, Atlantic City, June 20, and its office will be open from 4 to 6 and 8 to 10 P. M. on Wednesday, June 20, and at appointed times during the meeting. The constitution requires that all fellows, officers, annual and permanent delegates, and reporters shall register with this committee.

Permanent delegates failing to register will be marked as absent by the Recording Secretary. Annual delegates must present to this committee a certificate of election signed by the president and secretary of their component society. Without such certificate they can not sit as members of the House of Delegates.

Every permanent delegate must present a certificate bearing the seal of the Society and signed by the Recording Secretary, and without such certificate he can not register, nor vote in the House of Delegates. Nominees for permanent delegates can not register as permanent delegates until after their election by the Society on June 21, when they will receive certificates from the Secretary so that they can obtain their appropriate badges.

All members of component societies who are in good standing are entitled to sit as associate members and have the privilege of discussing papers in the general session, but have no vote nor the right to take part in the discussions of the House of Delegates.

The rates at Haddon Hall on the American plan, are: Rooms with running water, one person, \$6 to \$8; two persons, \$12 to \$14 per day. No. 2. Rooms with bath, one person, \$10; two persons, \$14 to \$20 per day. If you have not already engaged a room it would be wise to do so at once.

Exhibits of instruments, books, pharmaceutical preparations, X-ray apparatus, etc., will be shown in the ground floor exchange of the hotel, and members are urged to avail themselves of this opportunity to examine the very latest improvements in these various departments.

All papers appearing by title on the program, whether read or not, thereby become the property of the Society. The author of each paper is required to give to the Recording Secretary a legible copy of the same BEFORE reading. The expense of alterations in a paper after it is in type, and the cost of illustrations, is borne by the author.

Excepting orations and the addresses of the President and Third Vice-President, the time to be occupied in the actual reading of a paper is limited absolutely to twenty minutes. Those opening the discussion are allowed ten minutes each, others five minutes each.

Certificates of Nominees for permanent delegates must follow the special form given in the Constitution on page —. They should be sent to the Recording Secretary at least **one week before** the meeting, so that the names may be presented to the Society for election.

Members desiring to present voluntary papers or reports of cases should first have their papers accepted by the Committee on Scientific Work and then apply to the Committee on Program for a position.

Papers and reports not presented when called for by the President can not be presented at a later time unless the regular order of business is completed.

All sessions will be opened promptly at the hour set, in order that the program may be carried out as planned.

The Board of Trustees will meet at Haddon Hall, Wednesday, June 20, at 8 P. M.

PROGRAM

Thursday, June 21, 1923.

Meeting of the House of Delegates, 10 A. M.

Speakers must announce their names. No member may speak a second time in any discussion.

Call to Order.

Invocation,

Rev. Marna S. Poulson, Atlantic City
Address of Welcome,

Hon. Edward L. Bader, Mayor, Atlantic City
Fraternal Greetings,

Dr. Clarence L. Andrews, President, Atlantic County Medical Society.

Report of Committee on Credentials.

Reading of Minutes of the 1922 Meeting.

Report on Permanent Delegates.

Nominees for Permanent Delegates.

Election of Permanent Delegates.

Report of Committee on Arrangements and Program, M. W. Reddan, Chairman.

Report of the Committee on Scientific Work, Geo. N. J. Sommer, Chairman.

Report of the Committee on Publication, Chas. D. Bennett, Chairman.

Report of the Corresponding Secretary.

Report of the Recording Secretary.

Report of Board of Trustees.

Report of Committee on Revision Constitution and By-Laws, Walter B. Johnson, Chairman.

Report of the Judicial Council.

Report of the Committee on Honorary Membership, Walter B. Johnson, Chairman.

Report of the Treasurer, Elias J. Marsh.

Report of Committee on Prize Essay, Alexander Marcy, Jr., Chairman.

Report of Committee on Public Hygiene and Sanitation, Gordon K. Dickinson, Chairman.

Report of Committee on Public Health Education, Philip Marvel, Chairman.

Report of the Delegates to the American Medical Association and to State Societies.

Report of Special Committees.

Each member of the Nominating Committee should present to the Recording Secretary his certificate before the opening of the afternoon session, so that the names of the Nominating Committee may be announced as indicated on the program. The Nominating Committee will meet at 5.30 P. M. in the committee room.

Thursday, June 21, 1923, 2:30 P. M.

Meeting of the House of Delegates.

Unfinished Business.

Report of Business Committee.

Miscellaneous Business.

General Session.

Reading of the Names of the Nominating Committee.

1. Address of the Third Vice-President,
Archibald Mercer, Newark
2. Dilatation of the Cervix Uteri, Podalic Version and Delivery of the Child Under Anesthesia.....James M. Hackett, Leonia
Abstract.—An earnest endeavor to establish a scientific point at which assistance should be rendered to women in difficult or long-continued labor from any cause. How to determine when to assist a woman in labor; the great advantage as a life saver of dilatation of the Cervix. Version and delivery during the first stage in many cases, and the methods of such procedure in detail, with a report of 300 cases of version.
Discussion by W. J. Harman, Trenton.

Thursday, June 21, 1923, 8 P. M.

3. President's Address,
James Hunter, Jr., Westville
4. Backache.....B. Franklin Buzby, Camden
Abstract.—Lantern Slides.
Discussion by Richard Ernest, Trenton, and Thomas B. Lee, Camden.
5. Report of Welfare Committee,
Wells P. Eagleton, Chairman

Friday, June 22, 1923, 9 A. M.

Meeting of the House of Delegates.
Unfinished Business.
Report of the Business Committee.
New Business.

10 A. M.

General Session.

6. Oration in Medicine,
Berthold S. Pollak
7. The Treatment of Malignant Disease by Means of the New Higher Voltage Shorter Wave Length Roentgen Rays.—Radium and Electrothermic Coagulation,
J. Thompson Stevens, Montclair
Abstract.—A discussion of the value of radiation therapy in the treatment of malignancy by three physical agents—roentgen rays, radium and electrothermic coagulation, with particular reference to such treatment when the disease is located in the breast, the cervix, and the uterus. The German method, the correct method in the light of present day knowledge, for the finding of the proper factors for treatment in the individual case. Demonstrated by lantern slides of patients before and after treatment.
Discussion by Charles F. Baker and W. E. Doremus, Newark.
8. The prevention and Relief of Heart Disease.
Harvey M. Ewing, Newark
Abstract.—1. Incidence of heart disease and its economic importance to the individual and to the community. 2. Heart disease heads the list of causes of death. 3. Sufferers from cardiac disease may be serious menace to public safety.. 4. Causes of heart disease. 5. Methods of prevention and prophylactic care of those suffering from, and of those pre-work as taken up by the N. Y. Association for disposed to cardiac disease. 6. Outline of the Prevention and Relief of Heart Disease.

7. Reference to same work as undertaken in the City of Newark.
Discussion by Charles E. Teeter, Newark.
9. A Few Important Facts in the Diagnosis of Plmonary Tuberculosis.

Marcus W. Newcomb, Brown's Mills

Abstract.—Family history. Presonal History. Previous history of diseases with special attention to pleurisy, with or without effusion. Blood spitting. Slight afternoon temperature. Loss of weight and strength. Method of examination—inspection, palpation, percussion and auscultation. Physical signs and symptoms.

Discussion by S. B. English, Glen Gardner, and Alexander Armstrong, White Haven, P.

Friday, June 22, 1923, 2:30 P. M.

Meeting of the House of Delegates.

Report of Nominating Committee.

Election of Officers.

Unfinished Business.

Report of Business Committee.

Miscellaneous Business.

10. Reform Diet as a Therapeutic Measure in Ophthalmic Practice,

George Huston Bell, New York City

Abstract.—There is a growing demand for a scientific supervision of the diet in health and disease. Do not mix heavy starches and proteids at the same meal. Starches are digested in the mouth and intestines and proteids in the stomach. What is the sense of eating foods together that fight and ferment in the stomach? Why not eat them separately and at different meals? It is the acid fermentation produced by these wrong food combinations which lead to Toxemia. Before putting patients on the "Reform Diet" we must get rid of infected teeth and diseased tonsils and all other foci of infection. All patients must be given the acid test for the "Three T's" (Teeth, Tonsils and Toxemia).

Discussion by W. D. Olmstead, Trenton, and Dr. Rose, New York City.

11. Musings of a Stomach,

Gordon K. Dickinson, Jersey City

Abstract.—Full of truths in physiology and phylogeny, written so that even a physician can comprehend it.

Discussion by H. B. Costill, Trenton.

12. Gastro-Intestinal Gases as Studied During Twenty-nine Years' Arctive Practice of Medicine in Atlantic City,

W. Blair Stewart, Atlantic City

Abstract.—Peculiarities of seashore practice. Dictetic studies as causative factors. Physical diagnosis vs. laboratory methods. Case history and the follow-up system. Secondary causative factors: Pseudo angina; Focal infections; Tooth and mouth; Typhoid fever; Age factor. Errors in diagnosis. Organic malignant types. When do cases become surgical? Medication.

Discussion (to be announced at time of meeting).

Friday, June 22, 1923, 8 P. M.

Concert, Reception and Dance.

(See Entertainment Program, p. 212.)

Saturday, June 23, 1923, 9 A. M.

13. Operative Reduction of Fracture of the Femur,

Robert E. Soule, Newark

Abstract.—Lantern slide illustrations. 1. Outlines of methods employed in the treatment of fracture of the femur. 2. Selection of cases requiring open reduction. 3. Selection of operative technique to be employed. 4. Selection of method of post-operative treatment. 5. Importance of physio-therapeutic measures in the early restoration of function following operation. 6. Arguments pro and con in the employment of different methods and their applicability. 7. Author's technique and report of four cases.

Discussion by J. P. Reilly, Elizabeth, and George H. Sexsmith, Bayonne.

14. Concerning the Computation of the Percentage of Permanent Disability in Eye Injuries, Under the Employers' Liability Act,

Elbert S. Sherman, Newark

Abstract.—1. Some general comments on the ace. 2. In individual cases there is often a wide divergence in the conclusions of different ophthalmologists, as to the percentage of disability. This is deplored and an attempt is made to point out the reasons for the lack of uniformity, and some remedies are suggested. 3. The method adopted by the Eye, Ear, Nose and Throat Section of the Academy of Medicine of Northern New Jersey, of estimating the percentage of ocular disability caused by injury, and comments on some methods and compensation tables used elsewhere. 4. Some practical applications.

Discussion by Schlichter, Elizabeth; Edgar Holden, Newark; Wallace Pyle, Jersey City.

Saturday, June 23, 1923, 2:30 P. M.

General Session.

15. Oration in Surgery,

Samuel Goodwin Gant, New York

Part I. The Local and Surgical Treatment of Chronic Diarrhoea.

Part II. Indications for and Technique of Local Anesthesia in Rectocolonic Surgery.

Abstract.—Both subjects illustrated by motion pictures. Part I. Classification of Ulcerative Colitis. Different types of lesions responsible for it. Appendicectomy, cecostomy and ileocecostomy operations employed in different cases. Part II. Local Anesthesia. Indications for in Rectocolonic Surgery. Solutions best. Different diseases in which they are indicated, as well as those in which they are not. Amount of solution employed in different cases. Technique.

16. Gastric and Duodenal Ulcer. Medical Treatment and Surgical Indications,

Fletcher Freeman Carman, Newark

Abstract.—1. Recent advance in knowledge. 2. Etiology—location. 3. Symptoms—complications. 4. Diagnosis—methods used. 5. Treatment—surgical indications. 6. A plea for more conservative treatment. 7. Lantern slide illustrations.

Discussion by Edward J. Ill, Newark.

Meeting of the House of Delegates.

Unfinished Business.

Report of Business Committee.

Miscellaneous Business.

Adjournment.

Entertainment at the Annual Meeting

Thursday Afternoon, June 21, 1923.

2:30 to 4:30—Cards, room 17, Chalfonte.

4:45—Tea and recital in main lobby of Chalfonte.

Thursday Evening, June 21, 1923

Informal dancing and cards following the stated program.

Friday Evening, June 22, 1923, 8 P. M.

Solo.....By Edward Prosser, Tenor

Solo.....By Powell Evans, Baritone

Miss Sarah Newell, Accompanist.

Duet.....By Messrs. Prosser and Evans

Address.....By Strickland Gillian

Coupon books containing the following coupons will be issued to every lady registered:

I. Rolling chair coupon, good for two ladies at any Skill Rolling Chair Station from June 21, 22 and 23, 1923, for one hour.

II. Life Guard Drill.

III. Net Haul on Million Dollar Pier.

IV. Hygia Pool.

V. Steel Pier Admission Ticket.

Visits to Children's Seashore Home.

Visits to Atlantic City Hospital.

THE AMERICAN MEDICAL ASSOCIATION

The A. M. A. Journal of May 26 is the San Francisco number giving announcements of the annual meeting. We note that the following New Jerseymen are on the program:

Dr. Fred H. Albee is given as from New York, but his residence is Colonia, N. J., and he is a member of the Middlesex County Society. He will occupy quarters in the moving picture theatre and will there give a talk on the history and use of motion pictures as a teaching medium, illustrated with motion pictures. He will discuss two other papers.

Dr. Wells P. Eagleton, Newark, will present a paper on Surgery of the Cerebrospinal Circulatory System in Suppurative Intracranial Disease; he will also discuss another paper.

Dr. Frederick M. Allen, Morristown, will read a paper on the Treatment of Diabetes with Insulin. He will also discuss a paper on Pancreatitis.

Meeting of the Welfare Committee, Medical Society of New Jersey.

A meeting of the Welfare Committee of the Medical Society of New Jersey was held in the Essex Club, Newark, on May 9, 1923. Present were Dr. Wells P. Eagleton, Chairman; Dr. D. C. English, Dr. George T. Banker, Dr. Henry B. Costill, Dr. Thomas Harvey, Sr., Dr. Frederick Quigley, Dr. Frank Pinneo, Dr. Julia Mutchler.

On motion by Dr. Banker, seconded by Dr. Pinneo, it was decided by the committee to pay the bills of the Hospital Standardization Committee, and that the report of the Hospital Standardization Committee to the State Society be submitted as part of the report of the Welfare Committee.

On motion of Dr. Quigley, it was decided

that all outstanding bills of the Welfare Committee be paid. The list included the bills of Joseph H. Gunn, executive secretary for legislative and secretarial work; Josiah Stryker, attorney, for drafting legislative bills, opinions on same, etc.; Albert C. Wall, drafting legislative bills, and of Convention Reporting Company, for copies of reports of Hospital Conference.

On motion of Dr. Banker it was decided that the cost of luncheons of the Welfare Committee members, while attending meetings of the committee, be included in the committee expenses. It was also decided by motion that the traveling expenses of the members of the Welfare Committee, incident to their attendance on committee meetings, be paid by the committee.

A general discussion was had, the policy to be pursued during the coming year by the Welfare Committee with regard to legislation. After discussion the matter was left to the chairman to deal with in his report to the State Society Convention.

It was further decided that the Welfare Committee approach Governor Silzer with a suggestion that the Governor designate a committee from the Medical Society of New Jersey to make a survey of health conditions and medical problems in this State, along lines similar to the survey that is being made in New York State by a committee from the New York State Medical Society, under designation by Governor Smith, that Governor Silzer may be guided by the survey and recommendations of the committee in his efforts to solve the medical and health problems in this State by new laws or regulations.

Joseph H. Gunn, Executive Secretary.

SCIENTIFIC MEDICINE VS. QUACKERY Should Ignorant Laymen Be Permitted to Treat the Sick?

From a splendid Original Article, by Dr. William J. Robinson, in the April issue of the Medical Critic and Guide. We can only give the concluding part, as follows:

Summary and Points of Emphasis.

1. The human body is a very complex and very delicate organism. To understand its normal mechanism (its physiology), and its abnormal derangements (its pathology or disease), requires years of theoretical study and practical experience.

2. The public is not capable of judging as to who is not a competent physician, any more than it is capable of judging as to who is and who is not a good steamship captain, a good electrician, a good chemist, a good engineer, a good astronomer, a good mathematician. Only competent boards from the respective professions or trades can decide that more or less satisfactorily.

3. Without laws and regulations for the practice of medicine, the country would be overrun by ignorant conscienceless quacks, deceiving, cheating and preying upon the public, and the damage to the people's health and the increase in mortality would be something fearful.

4. To talk of free competition in the practice of medicine shows a defective mentality. Medicine is not a trade like selling shoes or

clothes. When a person has had his health ruined or has been driven to an untimely grave, then it is no consolation to him or to his relatives to know that the doctor who treated him was an ignorant, unlicensed quack. It is too late. The quack should not be given the opportunity to succumb in the survival-of-the-fittest struggle, after he has done incalculable damage; he should be prohibited from entering into the struggle; he should not be punished after his misdeeds; he should be prevented from committing any.

5. The laws that we demand for the regulation of medicine are, most emphatically, not for the protection of the medical profession, but for the protection of the people. We are willing to admit anybody to the practice of medicine who can give proof that he is more or less competent to perform the delicate duties of a physician.

6. That there is incompetence and ignorance in the medical profession is admitted, but the remedy for that is not letting down the bars for all comers to enter, but raising them higher still, so that eventually only really competent and intelligent men and women may be entrusted with the heavy responsibilities of healing the sick.

7. The regular medical profession is aware of its shortcomings, but it is honestly trying to eliminate them by raising the standard of preliminary education, by enlarging the curriculum, by increasing the number of years required for completing the medical course, by extending the laboratory facilities, by recommending hospital experience as an obligatory part of medical study; in short, it is doing everything in its power to raise the standard of the physician of the future. While as to the quack, all he demands is the abolition of all criteria, of all standards, of all educational requirements.

8. The statement that drugs are absolutely useless, and never are of any benefit in the treatment of disease, proceeds from the ignoramus who have not used and are not familiar with the action of drugs. I make the positive statement that there is not at the present time a single physician of any eminence who denies the value of drugs. He may object to the abuse of drugs, to too great reliance on them, but not to their proper use. And there is not a single physician who does not use some drugs occasionally. And what's more, the fakers who publicly decry the use of drugs as poisons use some few drugs in their practice, in secret. But, of course, the drugs they use are "all right," because they are "mild and harmless"—so they say.

9. The idea conveyed by quacks, naturopathic (so-called) doctors, chiropractors and that ilk, that the scientific medical profession treats by the means of drugs only, is utterly false. There is not an agency in the world, material or immaterial, which the regular profession does not use in the treatment of disease. As to diet, it is an important subject of study with us, and the real advances in the science of dietetics and the nutritional value of foods are made by the medical profession, and the physiologists and chemists who work hand-in-hand with it.

10. No conciliatory attitude is to be adopted with mental healers, absent-treatment quacks, quack psychoanalysts, chiropractors,

etc. The greater part of their claims is impudent fraud, while the grain of truth in some of the cults is incorporated in the regular system of medicine.

11. As to various quack institutes, consumption and cancer specialists, lost-mannood professors, etc., etc., they should be treated as ordinary bunco-steerers or highway robbers are. They are worse than common thieves. They deserve no consideration, as they show none toward suffering humanity.

12. There is no excuse or reason—except a selfish one—for the existence of different "schools" of medicine. The fundamental subjects—nine-tenth of all studies—are the same in all schools. On the subject of treatment, the schools are coming closer together and the time is near when there will be only one school of medicine, just as now there is only one school of chemistry, one school of engineering, one school of physics, one school of astronomy. And that school will be the school of regular scientific medicine.

Country Doctor Wins Approval of Profession.

From New York Tribune, May 24.

The old-fashioned country doctor came into his own yesterday. He was officially indorsed and eulogized, although not without lively controversy, by prominent physicians speaking at the final sessions of the annual State medical convention at the Waldorf-Astoria. The particular feature for which he was admired is that he administers to mental ills first and uses more common sense than medicine in his treatment.

Dr. Frankwood E. Williams, of New York City, Medical Director of the National Committee for Mental Hygiene, was the principal defender of the general practitioner, and intimated that the specialist, while doing magnificent work, was prone to overestimate his own importance as compared with the family physician, who was godfather as well as medical adviser to the family.

"Of every five persons who think they are sick, only one is sick organically," Dr. Williams said. "But every man who thinks he is sick, is sick—if not organically, then as a matter of concern to the neurologist or psychiatrist. Five hundred years ago the twenty per cent. physically sick were likely to die, but today they are saved. However, the eighty per cent. who are today ignored received attention in medieval times, and consequently were better off than the eighty per cent. today. The amount of illness we doctors treat, compared with the amount of illness actually existing, is hardly a drop in the bucket. There is not a single officer of public health in the country, from the viewpoint of practical requirements of the general public. As a result of all this innumerable persons have taken to fads of all sorts in the matter of health cures, ending in occultism just as once upon a time they used charms and incantations." Numerous physicians rose for the discussion immediately following this address. Among them was a guest from Washington, Dr. T. A. Williams, author of several books on children's ailments, who admitted that a large part of the criticism aimed at the medical profession by writers as recent as Bernard Shaw, and going back to the days of

Moliere, was justified. At the same time he pointed to the marvelous work done in tuberculosis, sures, surgery, preventable measures and the lengthening of the years of human life in the average.

Dr. Thomas W. Salmon, of Larchmont, followed with a paper on recent advances in treatment of psychoneuroses. He said the average attitude today was to accept Freudian theories of psycho-analysis, with the important reservation of relegating sex to a position of average and not paramount importance. He declared also that the institution of the family is not always or even mostly an unmixed blessing, and recommended both places for care of children and "parentoriums" for "bringing up" of parents. A paper was read by Dr. Simon Flexner on bacillary dysentery, mostly of a technical nature, but including the statement that no serum has been found as yet to combat the type of sleeping sickness that follows influenza. Dr. Barton C. Hirst, of Philadelphia, presented a paper on cancer, saying there is probably five times as much of this disease prevalent as is reported to physicians. There was also continued discussion of insulin treatment for diabetes.

Dr. Orrin Wightman was elected president and Dr. Edward Livingston Hunt re-elected secretary. It was officially stated that this has been the most satisfactory convention on record, attended not only by physicians throughout the State but also by distinguished visitors from all parts of the country and foreign countries as well.

Therapeutic Notes.

Appendicitis.—In appendicitis trust to the physical signs rather than to the symptoms. Local tenderness remains when the appendix has perforated or is gangrenous, even though there be no abdominal tension.—Sir D'Arcy Power, *Surgical Aphorisms*, Clin. Jour.

Bone Suppuration the Basic Cause of Renal Calculus in Twenty Cases, Following War Wounds.—H. Ernest Paul, Canadian Medical Association Journal, finds in the twenty cases he reports, evidence of a definite etiological relationship between the bone suppuration and the formation of renal calculi. He feels confident that infection is a definite contributing cause, if not the most important cause, and suggests that if every case of nephrolithiasis could be investigated with sufficient thoroughness, a history of a preceding systemic infection could be elicited. Such being the case, the removal of calculus from the upper urinary tract should be considered only an important preliminary step in the cure, and treatment of the concurrent infection should be carried out thoroughly if recurrence is to be avoided.

Diabetes Cured by Insulin.—Exhibiting case after case of persons afflicted with diabetes who have been restored to normal health, Dr. A. I. Ringer, at a clinic held in Montefiore Hospital, before nearly a hundred doctors and specialists in metabolic diseases, revealed in detail the use, manipulation and efficacy of the newly discovered specific for diabetes—insulin. "The years 1922 and 1923 will be

memorable in history," said Dr. Ringer, "as marking the discovery of this new drug, a specific for diabetes. We have other specifics, such as mercury, salvarsan, and so on, but these are distinguished by the fact that they add something to the animal system which is not normal to it. Insulin is in a class by itself: it adds something to the system which is normal in a healthy state and which, when lacking, produces diabetes. No one need die today who is suffering from diabetes," he declared, at another point.

Hospitals; Sanatoriums.

Salem County Memorial Hospital.—The following is the report of the hospital for the month of April: Admissions, 50; discharged, 46; operations, 22; births, 11; deaths, 3; treated at the clinic, 62; accidents, 11.

All Souls' Hospital Training School.—A class of six nurses was graduated from All Souls' Hospital Training School recently, the ceremonies closing with a dinner and dance in the nurses' home. The graduating exercises were held in the hospital chapel.

Nurses Receive Diplomas.—Nine nurses received their diplomas from the Cooper Hospital, of Camden, last month.

Bonnie Burn Sanatorium.—Dr. J. E. Runnells, superintendent, reports for the month of April the following: Since March 31, thirty-nine patients were admitted, eighteen males and twenty-one females; twelve went to the preventorium. The admissions were: Pre-tubercular, 12; incipient, 3; moderately advanced, 7; far advanced, 16; bone tuberculosis, 1. The number of patients; May 1, was 267, including eighty-three children in the preventorium and seventy-five out-county patients.

Tuberculosis Sanatorium, Blackwood.—Plans have been made for the building of a sanatorium here by the Camden County Board of Freeholders. When the building is finished the sanatorium at Ancora will be closed and the patients removed here. The sanatorium building at Ancora may be used by the almshouse-committee for paid patients of the almshouse.

Sanatorium Staffs Appointed.—The Essex County Board of Freeholders recently made the following appointments: Advisory staffs for Essex Mountain Sanatorium, Verona and the Isolation Hospital, Soho, and a long list of consulting physicians, surgeons and specialists for the latter were appointed. The present advisory staff at Verona was reappointed, including Dr. Clarence V. R. Bumstead, Dr. Carl Ill and Dr. I. Edward Gluckman, of Newark; Dr. Ralph H. Hunt, of East Orange, and Dr. James Spencer Brown, chairman, of Montclair. The Soho advisory staff is Dr. Clement Morris, Dr. Sarah C. Smalley and Dr. Peter F. Motzenbecker, of Newark; Dr. James Minor Maghee, of West Orange, and Dr. William H. Areson, of Montclair. Dr. James S. Plant was named director of the juvenile mental clinic.

Marriage.

SCOTT-EAGLESTONE.—In Baltimore, Md., April 14, 1923, Dr. Karl M. Scott, of Atlantic City, N. J., to Miss Marion Eaglestone, of Baltimore.

Deaths.

DOLAN.—At the Neurological Institute, New York City, May 7, 1923, of sleeping sickness, Dr. Thomas E. Dolan, of Elizabeth, N. J., aged fifty-eight years.

Dr. Dolan was born in Elizabeth and received his early education in the public schools and in John Young's School in Elizabeth. For three years he studied medicine at the University of Dublin, Ireland. He was a graduate of the Jefferson Medical College, of Philadelphia, and was for six years surgeon for the American Steamship Line, sailing out of Philadelphia for European ports. With former Mayor Rudolph Blankenburg, of Philadelphia, and a relief party, Dr. Dolan sailed on the steamship Indiana to aid the starving victims of the Russian famine in the early nineties.

For twenty-eight years Dr. Dolan had been practicing medicine in Elizabeth. He served as city physician for eight and one-half years and was twice elected to the Board of Health. While on that body he was chairman of the committee which established the laboratory for the examination of the city's milk supply, following a campaign to reduce infant mortality. Dr. Dolan was also a member of the committee responsible for the building of the huge stack at the Bayonne Refinery to eliminate acid odors.

During the mayoralty campaign in 1920 there was a strong boom for Dr. Dolan, sponsored by Democrats who wished to make him a candidate for mayor. At a meeting of the Clinical Society of the General Hospital, Elizabeth, the following resolutions were unanimously adopted:

"Dr. Thomas E. Dolan, a member of the Clinical Society of the Elizabeth General Hospital, died on May 7, 1923.

"Dr. Dolan was a native of Elizabeth and practiced his profession in our city for a number of years, endearing himself to a large clientele.

"He performed his civic duties with special regard for the public of Elizabeth, functioning for a number of years as city physician and later as a member of the Board of Health. He was active in the institution of many of the splendid sanitary measures for which Elizabeth is noted.

"In his death we lose a beloved physician and a good citizen. We extend to the bereaved family our deepest sympathy.

"(Signed)
"Stephen T. Quinn, M. D., Norton L. Wilson, M. D., Arthur Stern, M. D., Committee."

FAISON.—In Jersey City, February 24, 1923, Dr. William F. Faison.

The Hudson County Medical Society, on April 3, adopted the following:

In the death, on February 24, 1923, of William F. Faison, M. D., of Jersey City, N. J.,

the community in which he lived, lost one of the most eminent physicians in its history, who had contributed unselfishly of his time, his attainments, and his substance to the welfare thereof, in many phases of public service.

Its citizens were deprived of a kindly, sympathetic minister of healing, whose utmost had been offered, without commensurate recompense, for the aid of their suffering poor.

His professional associates will miss a friend, a leader, a teacher, an inspiration.

The Hudson County Medical Society desires to express on behalf of all its members their deep sense of privilege in having known and loved him, and to convey to his family their very sincere sympathy in their bereavement.

S. A. Cosgrove, chairman; O. R. Blanchard, Wallace Pyle, C. D. Hill, William M. Doody, committee.

CHATTIN.—In Newark, N. J., April 1, 1923, Mrs. Gertrude Chatten, wife of Dr. John Franklin Chatten of Newark. Mrs. Chatten was born in Masonville in 1874. She graduated as a nurse at the Mercer County Hospital, Trenton. She married Dr. Chatten in 1898. They moved to Newark in 1910. She was a member of the Republican County Committee, elected at the primaries in 1921.

Personal Notes.

Dr. James Hunter, Jr., has been elected medical inspector of the Westfield schools by the board.

Dr. C. M. Sherron, Salem, was elected recently president of the Salem Country Club.

Drs. William P. Thorne and R. J. McDonald, Butler, have been elected members of the Wallkill Golf Club of Franklin.

Dr. Fred W. Owen, Morristown, has offered a prize to the young woman graduate of the high school whose character and personal habits have most highly influenced for the right her fellow students of her own sex.

Dr. Martin J. Synnott, Montclair, has been appointed a member of the City Board of Health.

Dr. C. F. Halsted, Somerville, and wife recently returned from a short stay in Atlantic City.

Dr. J. S. Winslow, Vineland, while adjusting his farm tractor had his shirt sleeve caught by a bolt, which began to wind his right arm into the machine. The sleeve gave way and the doctor escaped with only a severe flesh wound.

Dr. G. VanVorhis Warner, Red Bank, is a member of the State Society Welfare Committee instead of Dr. Beveridge, as given in the May Journal. Dr. D. M. P. Magee lives in Long Branch instead of Red Bank. Dr. Philip Hochbruckner, Farmingdale, has moved to New York State, and Dr. W. G. Herman has been elected the delegate to the State Society in his place.

Dr. Henry B. Orton, Newark, read a paper on "Carcinoma of Bronchus, Removed Bronchoscopically," at the sixth annual meeting of the American Bronchoscopic Society, at Atlantic City, May 9, 1923.

Dr. Robert L. McKiernan, New Brunswick, who was about leaving the city to attend the Mayo clinics at Rochester, received word of

the sudden death of his father in Connecticut, which compelled him to give up his trip.

Dr. George A. Vanwagenen, Newark, has returned to Newark from his winter's stay at St. Petersburg, Fla.

Dr. John Dennis, Newark and Homestead, Fla., is now located at Washington, D. C.

Drs. George C. Albee, South Orange, and L. M. Demarest, Newark, assisted by two nurses, held a clinic for examination of babies for the May Day exercises at the Redmond House. No baby was found under ninety per cent.

Public Health Items.

Newark Health Report.—The health department report for March shows: Total deaths, 569, a death rate of 15.4 per 1,000 population. The principle causes of death were: Influenza, 31; tuberculosis, 47; cancer, 35; apoplexy, 34; pneumonia, 86; Bright's disease, 43. There were 935 births.

New Jersey Health Report.—During the month of February, 1923, there were 4,818 deaths reported to the State Department of Health; 569 of children under one year of age, 1,935 of persons aged sixty or more years. The death rate was 16.95. The principle causes of death were: Diphtheria, 55; influenza, 250; tuberculosis, 265; cancer, 253; pneumonia, 540; Bright's disease, 381.

Increase of Typhoid Fever in Manila.—Typhoid fever, says Dr. Proceso Gabriel (Rev. de Med. y Farm) has shown a steady increase in Manila during the last few years. From an average death rate of 20.73 per hundred thousand in 1911-1913, mortality increased to 50.94 in 1914, 83.91 in 1918 and 102.60 in 1920. In 1921 and 1922 the increase persisted. Artesian wells, flies, stables, unsanitary restaurants, together with the practice of filling hollows with refuse, are said to be the cause.

Nutrition and Tuberculosis.—The well fed resist tuberculosis well; the underfed yield readily. Every attack of indigestion, every missed or partially consumed meal has its adverse effect on nutrition at any age of life.

The rich business man who hastily consumes a scanty breakfast of toast and coffee and works hard all day in an office with only a hasty lunch at noon can not consider himself well fed even though he consumes a full meal in the evening. His child who refuses at table wholesome articles of food, such as bread and butter, vegetables and meat, can not maintain a satisfactory degree of nourishment. . . . A lack of knowledge of food values is very common, especially in cities where delicatessen products made to tempt the eye and palate too often in the busy urban life take precedence over wholesome soups, roasts and stews from the home kitchen. It should not be forgotten that the fatty articles of food, including butter, fat meats, cream and olive oil, are especially valuable in building up resistance to tuberculosis; but the diet must be suited to the age of the individual. Bread and butter, meat and abundant vegetables must not be slighted simply because milk and eggs are so commonly mentioned as ideal foods.—F. C. Smith, Pub. Health Rep.

THE MEDICAL SOCIETY OF NEW JERSEY

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First Vice-Pres., WELLS P. EAGLETON.....Newark

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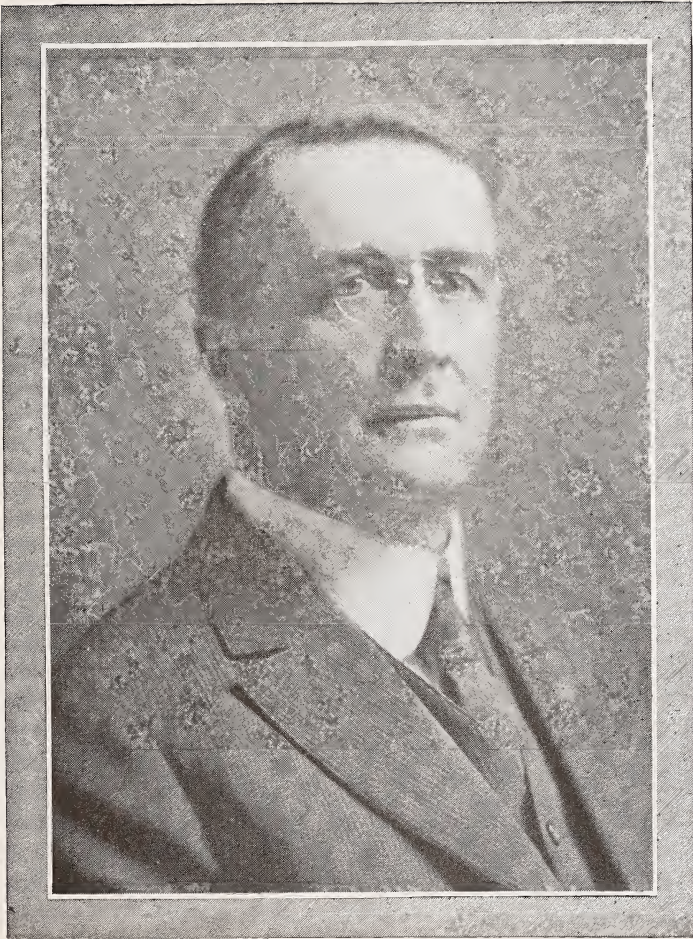
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WESTVILLE, N. J.

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PRESIDENT'S ADDRESS

Delivered at the 157th anniversary of the Medical Society of New Jersey at Atlantic City, N. J., June 21, 1923.

By James Hunter, Jr., M.D.,
Westville, N. J.

A writer has said that: "All empires, all States, all organizations of human society are, in the ultimate, things of the understanding and the will." Further that: "Behind the short-sighted governments that divide and mismanage human affairs, a real force for the world unity and world order exists and grows."

We are all ready to concede the fact that all organizations of whatever type are things of the understanding and will, but the thought contained in the second statement is not as fully appreciated as it should be. Behind all our human efforts, faulty, feeble and oftentimes misdirected, as they are, a real force for world unity and world order exists and grows, and this last thought is the balance wheel of the universe, for, after all, as Lord Cecil said of the League of Nations: "It is a human institution," which is but another way of saying it is not a perfect one. Nothing human ever is. But we strive, nevertheless, toward the heights, no matter how frequently we fall, we fall to rise again, and continue the struggle ever and always upward and onward. Our State Society opens today its 157th annual meeting, and in our progress through the century and more of our existence we have striven for the higher things in the medical life.

Let Article 2 of the Constitution of our State Society illuminate us for a moment, as we pass along.

ARTICLE 2, PURPOSE OF THE SOCIETY.

Object—The purpose of this Society shall be: First, To federate and organize the medical profession of the State of New Jersey. Second, To unite the similar or-

ganizations of other States, to compose the American Medical Association. Third, (and most important), To advance medical science and elevate professional character; to safeguard the material interests of the profession and promote friendly relations among its members; to educate the public in preventive medicine and hygiene, and in all to render the medical profession most capable in its service to humanity.

It is good at times for us to return to the fundamentals of the foundations upon which we have in the past, and continue in the present to build, in order that we may keep ever fresh in memory the exalted motives animating the thought and purpose of the men who organized and laid the corner-stones of this stately old medical society.

I say it is good to review these facts occasionally, for the reasons that at times they are lost sight of in the hustle of the busy workaday world, with its many vicissitudes.

Those of us who have served the society upon the various committees through which it functions, know only too well how frequently these primal motives upon which the society was founded are lost sight of by the public, and at times by our own membership.

This failure to appreciate the motives underlying our organization is pardonable, compared to the confusion that exists in both the public and medical mind, as regards the responsibilities and functions of medical organizations in reference to the public, with its Federal, State, county and community organizations. Here lie the roots and reasons why the public and their legislative representatives have always misunderstood the real purposes and functions of our society, especially in the realm of the many health problems appertaining to communities, Federal and State.

The old view that all forms of public health work are only forms of profes-

sional philanthropy still prevails, both in medical and lay minds. The thought originated in those early days, when we, as an organization and as individuals, gave so generously and freely of our service in such matters. It is time that we now ceased from pauperizing the public in these matters, time for us, through our organization, the State Society and its committees, to educate the public, to bring them to realize that these problems are theirs, and theirs only. We are part of this public, and our education and training fit us as expert councilors to the State upon all subjects of public hygiene.

As such we should be consulted, should have places upon all boards having medical problems to solve—delinquents, defectives, insane or criminals, with which to deal.

When the public and their representatives awaken to this broader view of their own responsibilities in these things, they will cease to accuse us, directly or by innuendo, of selfish and mercenary motives, whenever we, through our various committees, appear before them in the interests of community health matters.

Once educate the public, as to their position in such matters, clear away the old and false ideas that the responsibility is *ours*, and they will get a new perspective, which will result in a different and, I hope, a better attitude toward our profession.

Indeed, there are those of our membership who question the methods of the Society in looking after matters pertaining to public health legislation, and feel that while our motive may be right, our methods are wrong, in that they tend to further the confusion already existing, as to where the responsibility rests or should rest in such matters. Dr. Frederick R. Green, of Chicago, Ill., says: "The enactment and enforcement of health laws are functions of the State. Physicians are not the guardians of health any more than lawyers are guardians of property."

"Our business is to give the people the benefit of our specialized knowledge, to show them how they can protect themselves if they so desire, and to insist, as a measure of justice, both to ourselves and them, that whatever services we furnish in giving them protection shall be adequately paid for. The public health movement has passed the philanthropic stage. Any plans for the future must consider health, as a public function, and must include the entire public, not as beneficiaries, but as participants."

When he have re-educated the public, leading them to see these problems, as their own (which they really are), theirs to finance, to solve and provide for; ours to advise and direct and assist, in their solution. When that time comes we will be in a position to advocate many things of vital concern to community interest, both in health and disease, without doing as we are at present, overworking our Welfare and other committees.

The State of New Jersey stands well in the vanguard in its application of modern methods for the care of the insane, defective, epileptics and tubercular subjects, but we have still other medical problems, which have become, through the increased cost of modern life and living communal, or, if you will, State health problems.

I wish to direct your attention for a few minutes this evening to one of the most pressing of these, namely, the proper and humane care of that large and growing class of patients, whom we designate as incurables.

The types of incurables I have in mind, as needing communal care would include those suffering from cancers and sarcomas in all their horrible and loathsome forms, whether of face, intestines, rectum, uterus, breast, stomach, kidneys or bladder; tabes, locomotor ataxia, paralytics, rheumatoid arthritides, industrial cripples, with insufficient compensation to provide the needed medical care and nursing.

Incurables of the types indicated, doomed to pain, suffering and inevitable death, lingering for short or long periods of time, many with loss of control over bowel and bladder, lying in their own excretions, with filth and bedsores added to the daily horror of their existence, present a most pitiable, if not the most loathsome picture with which we, as a profession, have to deal.

For such as these, no tongue can paint the inferno of pain and suffering through which they pass, even with all the care that wealth can supply, what then must be their condition, when the means are not forthcoming, or, perhaps, entirely wanting, to provide medical care and attention. For this last-named group, death holds no terrors, but becomes, indeed, an angel of mercy and relief.

Sympathy should go first to where it is needed most, and where, may I ask, is it more urgently needed than in the proper and humane handling of such poor unfortunates, to the end that they may have what relief, ease and comfort is humanly

possible in those hours of pain and torture preceding death.

"Unto the prison house of pain none willingly repair—

The bravest who an entrance gain

Reluctant linger there—

For pleasure, passing by that door, stays not to cheer the sight,

And sympathy but muffles sound and banishes light."

Ah, me, the prison house of pain! What lessons there are bought!

Lessons of a sublimer strain

Than any elsewhere taught;

Amid its loneliness and gloom, grave meanings grow more clear,

For to no earthly dwelling place seems God so strangely near!

We have in this State some ten to fifteen thousand such cases of incurables, with absolutely no provision for their proper care. The larger number of these cases occur among that great middle-class of our population, with modest incomes of from one to three or four thousand dollars per year. The average family consists of four or five members, and in many cases additional dependents. With such meagre incomes they have to manage their finances very carefully to get by without going into debt, even when in good health, with the present high cost of living, housing, clothing, food. When sickness comes to this class it must be brief, if the increase required for medical attention and nursing does not place them in debt. But when the type of disease proves to be a lingering one, with death as an inevitable ending, they find it impossible to provide the necessary medical attention, and the patient suffers, as a consequence. The incurable is justly entitled to humane, cleanly and sympathetic care, but the prolonged duration of his sufferings in many instances makes this care prohibitive for those of modest incomes. Families of such modest incomes make up the larger portion of our population, they are the bone and sinew of our industrial life. We have no public hospitals in this State that will receive such cases for fees within the reach of this great class, and private hospitals are prohibitive to them.

Both private and charitable institutions that attempt the care of such cases find it difficult to keep the proper type of nurses and attendants, on account of the repulsive character of the duties involved in the proper care of this type of cases.

This State, with its population of four millions, four thousand of whom are physicians, has ten State institutions, and about two hundred sanatoria and charitable institutions, public and private. A few of the latter care for a limited number of incurables, who can meet the required fees.

Alms-houses excepted, there are no public hospitals in the State to receive and care for such cases, their beds being insufficient to care for the acute cases in surgery and medicine.

The State recognizes its responsibilities for the care of the insane, defective, delinquent, epileptic and tubercular cases, why not for the incurable?

Modern civilization should provide for the care of the incurable, with some humane method of hospitalization, either township, municipal, county or State. This could, with proper organization, be furnished to cases with limited financial means at cost. They would in this way receive care and attention that would be impossible for them to, amid their meagre home surroundings, have.

During the year of 1922 we had a mortality of over 8,500 deaths from incurable diseases, about 25 per cent. of our annual death rate, and this average holds good from year to year. Think then of the vast number of incurables we have with us at all times, and yet no adequate provision for their humane care. Dying, suffering humanity calls to us for help. Shall we ease the remaining days of these helpless ones, with some practical scheme of hospitalization; whether State, county or municipal matters not, so far as they are concerned, so that their pain and discomfort are eased and rendered more bearable during the period preceding their final relief by death.

Finally, while we, as medical men, should advocate and assist in bringing about the conditions necessary for the relief of this and all other classes of sufferers, let us ever remember that such problems, with their responsibilities, belong, and rightly so, to a public, of which we are but a part.

The need is imperative and urgent. The responsibility is communal, hospitalization the solution, whether municipal, county or State, matters little, except from the economics involved. Relief for this great class of sufferers is a duty those in health and strength owe to those in the "House of Pain." Let us then, as an organization, now, as in the past, do our part, point out the need and urge the necessity for the relief of the incurable within our borders.

then will our duty bear fruition, and we will realize with Gladstone that "Duty is a power which rises with us in the morning and goes to rest with us at night. It is co-extensive, with the action of our intelligence. It is the shadow which cleaves to us, go where we will, and which only leaves us when we leave the light of life."

PAY CLINICS*

By **Eden V. Delphely, M.D.,**

New York.

In delving into the subject of pay clinics, we are seeking after the truth, and although the truth may not "make us free," it will at least in this instance throw some light upon and give us a better understanding of this most interesting and imperatively important subject under consideration. For the last thirty-four years the present speaker has been a private soldier in the ranks of the great army which is fighting the battle against the legions of sickness and death, and what he says on the subject is based on his observation and experience. The medical is the most altruistic profession on the face of the earth—not even excepting the clergy, and some of them are really altruistic—because the practitioners of medicine are daily exposing themselves to all sorts of contagious diseases at all times of the day and night, freely and willingly, and often without hope or expectation of pecuniary reward. The medical profession, constituting less than one-sixth of 1 per cent. of the population of this city, is doing 95 per cent. of the medical charity, is doing it cheerfully and is willing and ready to continue to attend and treat sick and deserving people for nothing if they cannot afford to pay for the services. When a clergyman brings a man to the realization of his sinful estate and gets him to join his church, he has acquired another man to help pay his salary; but when a physician snatches a man from the jaws of sickness and death and restores him to his family in health and strength, he loses all income from that source until the man disobeys the laws of health and the warnings, which the physician has given him how not to be sick, in the endeavor to destroy his own

source of income, or has some misfortune befall him and is again brought under the physician's care.

The general medical practitioners of the present day are not the absolute ignoramus which so many would have you believe. According to the secretary of the New York State Board of Medical Examiners, the time spent in getting an education from the time when the person begins in the primary school until he is ready to begin the private practice of medicine and earn his own living is as follows:

| | |
|---|----------------------|
| Time spent in the primary and grammar schools | 8 years |
| Time spent in the high school | 4 years |
| Time spent in the academic school | 2 to 4 years |
| Time spent in the medical school | 4 years |
| Time spent in the hospital as interne | 1 to 2 years |
| | <hr/> 19 to 22 years |

Therefore, if he begins school at the age of six years, he will not be ready to begin to earn his own living by the practice of his profession until he is from twenty-five to twenty-eight years of age; and the time and money spent in obtaining his professional education, from the time he graduates from the high school, at the rates of compensation ordinarily paid to other persons of the same age, is estimated to be about \$20,000. Moreover, during the course in medicine he receives instruction of from 5,000 to 6,000 hours and is also required to put in from 2,000 to 3,000 hours' study "after hours" in order to keep up with his classes and graduate at the end of the course.

It has been quoted this evening that "only the very rich and the very poor receive the best medical treatment." The present speaker most emphatically denies the truth of that statement. It was first made by a teacher in one of our eastern medical colleges in a lay magazine, and he apparently found it necessary to reinforce the value and bolster up the effect of that statement by the insertion of half-tone pictures of his wife and children. The average people—the great middle class—are receiving the best attendance and treatment which medical art and science is able to give to any one, and that by the modest, unassuming general practitioners of medicine, who do not exploit themselves or indulge in the latest fads or untried fancies, but who go quietly and industriously among their patients, diagnosing their ills and curing their maladies without the beating of drums and clashing of cymbals or the open or insidious advertising which is so common among managers of the "public," "free" or "pay" clinics.

*An address delivered in part in the discussion on Pay Clinics before the Hospital Social Service Association at New York Academy of Medicine on Wednesday evening, April 18th, 1923. From N. Y. State Med. Jour.

Statements are often made about the medical treatment of the poor. Who are the poor? The first speaker, this evening, said that 87 per cent. of the middle class earned less than \$2,000 per year, and that one-third of that number earned but \$800 per year. In the April number of the New York State Journal of Medicine, received recently, it is stated editorially that the average income of practitioners of medicine in New York State is but \$900 per annum. If the income of any one class is larger than that of another, the former is certainly not entitled to receive charity from the hands of the one receiving the smaller income. If a physician is wealthy, it is very seldom that it is because he has earned and saved it in the practice of his profession. It is more often because he has inherited wealth, been bequeathed wealth, married wealth, or has acquired it in some business undertaking outside of the practice of medicine. A few years ago, one of our oldest medical colleges—the one whose teacher made the statement about only the very rich and the very poor receiving the best medical treatment—made an investigation into the status of its own graduates and found that only about 10 per cent. of them were earning their living entirely from the practice of medicine and unassisted by any other means of support. Inasmuch as the great foundations have been organized to give free medical treatment to the poor, and since the average physician's income is far less than the maximum and very near the minimum quoted, have they considered the organization of a foundation to give the physicians housing, clothing, food and other necessities of life at a similar under-cost rate? If they have or should do so, do they imagine for a moment that any self-respecting physician would so far forget his independence and manhood as to accept such charity, for giving medical treatment for \$1.57, which costs \$2.03, is charity and nothing but charity.

In determining the cost of living per family, the investigators and uplifters are accustomed to consider a family as consisting of five persons, while in fact the following are the real statistics.

| | N. Y. C'y2 | N. Y.St.3 | U. S.2 |
|--|------------|-----------|------------|
| Number of families... | 1,129,656 | 2,225,000 | 24,351,676 |
| Number of children... | 1,692,251 | 3,010,000 | 35,473,382 |
| Average number children per family.... | 1.41 | 1.35 | 1.46 |
| Average number persons per family.... | 3.41 | 3.35 | 3.46 |

In other words, when the investigator estimates the cost of living on the basis of five persons per family, the result is based

upon a number which is about 50 per cent. too high. During the year 1913—the last year in which we have reliable statistics—the foreigners in this country not only earned enough to feed and clothe themselves and to pay their other necessary expenses, but had enough left to send \$300,000,000 to their friends and relatives in Europe⁴. Does that look as they needed medical charity? Moreover, during the year 1921, the people of the United States spent the enormous sum of \$22,000,000,000 for luxuries alone⁴. Does that look as if they were too poor to pay a private physician a few dollars occasionally for medical service and treatment? Bear in mind that not every person needs to be under a physician's care, even every year.

It has been said that "medicine is expensive," but it is not nearly as expensive as the luxuries, many of which may be either the direct or indirect cause of the illnesses. A physician's remuneration should be directly in proportion to: (a) The good that he does the patient; (b) the patient's ability to pay for the services; (c) the time and work the physician gives to the case; (d) the cost of the physician's preparation for the kind of work he does; (e) the physician's ability to earn, and (f) the physician's overhead expenses for doing business. If a lawyer charges a certain percentage—usually 2½ per cent. of the value of a man's estate to administer it—why should not a physician charge a relatively equal, or even a larger, amount to prevent the need of such administration?

Something has been said about the adequacy of medical treatment, and the first speaker referred to the general practitioner's "looking at a man's tongue and giving him a pill" in cases of pneumonia. In his thirty-four years of practice of medicine in this city, the present speaker has mingled with all classes of physicians in all parts of the city and he has never even heard of a case of pneumonia being so treated. There is altogether too much sneering at the family physician. A few years ago, the New York city commissioner of health read a paper before the Medical Society of the State of New York on "The Private Physician and the Department of Health,"⁵ insinuating that the family physicians were inefficient; and yet, by his own statistics⁵ of the examination of school children, the family physicians found a higher percentage of deviation from the normal—except in eye and teeth cases, in

which cases specialists were employed by the department of health—than did the official examiners of his own medical household.

The first speaker questioned whether the general practitioner could afford to give the adequate amount of time to properly examine the patient for the amount charged him. Inasmuch as the general practitioner always has been able to give the proper amount of time for the thorough examination of his patients and his overhead expenses will still continue, will the taking of his patients from him and treating them at a "pay clinic" at "cut rates," tend to increase or decrease his ability to give his services at the present rate and still be able to earn enough to pay his rent, his overhead expenses and to support and educate his family? How about the medical college behind and responsible for the "pay clinics" competing with its own graduates?

The practice of medicine does not consist entirely of examining the patient and prescribing remedies for or operating upon him. A large part of a physician's success depends upon the personal equation, the belief of the patient in his ability to cure—the same mental suggestion which has been practiced from the time of Aesculapius and recently evolved into such cults as Eddyism, miscalled Christian Science, and Coueism with the repetition of "ca passe, ca passe" and "every day in every way, etc., etc." Much has been said of hospital advantages, which cannot be obtained at the person's own home, and while such is the fact in a few cases, nevertheless there are many serious and even dangerous operations performed daily at the patients' own homes, with equally as good results as in the hospitals. One of the oldest and best surgeons in this city, the attending surgeon to one of the wealthiest and most exclusive hospitals, so operates with his own sterilizers and instruments. The present speaker has also so operated and has been so operated upon and is a living example of the effect of such work from the patient's point of view. Whether he can be operated upon at home depends upon the patient's ability to have a good, clean, well-lighted, well ventilated room, with a few appropriate tables, hot and cold water, and a competent and capable person to give him the proper care.

Have any bodies of the medical profession taken a stand in regard to "pay clinics"? The Board of Trustees of the American Medical Association met at Chicago, November 10-12, 1921, and among

other things it arrived at the following conclusions regarding "pay clinics":

"The principles deemed basic are: (1) That the patients should be received by the clinic only when sent by the family physicians; (2) so far as possible the patient should be returned to the family physician with written information and suggestions; (3) that the fee charged by such clinic should not be less than that usually charged in general practice, so that, as far as possible, competition of the clinic with the general practitioner should not occur, and the chief consideration should be the public and the medical profession."⁶ (The above was also adopted by the Medical Society of the State of New York, May 21, 1923).

An editorial in the Journal of the American Medical Association, states, among other things, that:

" . . . The real function of the diagnostic clinic is to handle those patients in whom the examination and diagnosis require the use of special apparatus not possessed by the average physician, or when the joint examination of several specialists is essential. . . . They should receive no patients able to pay a fee, unless the patients are referred by the family physician—if they have one—or are received with his knowledge and approval; and to prevent the appearance of competition, the fee charged by the clinic should be no less than that charged for like service by the family physician. . . . It must be remembered that the family physician, after all, is the most important factor; it is through his intimate contact and personal acquaintance with the patient that sound advice and proper treatment can be secured for the great majority of sick people."⁷

Now, what are the facts in the conduction of the ———* pay clinic, as compared with the foregoing? "One dollar for each visit for examination and treatment."¹ At the end of the first year; " . . . over 22,000 patients were admitted . . ."¹ " . . . The Consultation Clinic has in the last sixteen months served 2,067 patients referred by 1,155 physicians."⁸ Regarding referred patients: "For this service, with consultation of specialists and blood and urine tests, the fee is \$10. Persons who do not complain of illness, but who wish to secure advice . . . The examining physician personally will give instruction and advice. The fee for this service is \$5."¹

On March 23, 1923, the Audubon Medical Society adopted the following: "That the Audubon Medical Society considers it

unethical for any physician to send a patient to the ——* Pay Clinic, or to any similar type of clinic, and that the secretary be instructed to send a copy of this resolution to the ——* Pay Clinic."⁹

As to the direct and indirect advertising by the ——* Pay Clinic, why it is ethical for the pay clinic to directly advertise to the public and not ethical for the private physician to do so? Since the dean of the medical college behind the ——* Pay Clinic is one of the members of a committee to revise the "Principles of Ethics" for the State Medical Society, does he intend to recommend the submission of a report to that effect?

One great danger of the project is that it is the thin end of an entering wedge for paternalism and socialism. Has not this country had enough of paternalism when, under the conditions obtaining during the World War, it became necessary for the Federal government to take over the railroads, telegraphs and telephones? Do we want any more paternalism than we can possibly avoid? Do we want our food, medical service, clothing, exercise, ideas, religion and everything else supervised and administered by a super-authority? Has such a scheme been a howling success in other countries? Are pay clinics necessary? Do they fill a want which has not already been cared for? Is not every general practitioner's office a pay clinic and a health center? Diagnostic clinics are on the wane, some have failed financially and have been abandoned. Does the State need others? Ninety to 95 per cent. of medical practice is of such a nature that it can as well be carried out in the general physician's office, with the instruments and apparatus in his possession, as it can be in the pay clinics; and the 5 to 10 per cent. needing further care can be properly attended to either by independent consultants or in the so-called "free clinics" already established, and which in this city number 168. In his thirty-four years' practice of medicine, the present speaker has never found a general consultant or a consultant specialist who was not perfectly willing to examine and treat a case referred to him for whatever the patient could afford to pay for the service, or for nothing if the patient was deserving, needy and unable to pay. This is even true of one of the specialists in the ——* Pay Clinic, now under special consideration; the present speaker has known such a specialist, and has referred cases to him for a number of years—long before there ever was a ——*

Pay Clinic. In such a city as New York these consultants and specialists are always available, while the ——* Pay Clinic is closed on Saturdays, Sundays and holidays.

These facts negative the idea that pay clinics are necessary for people of moderate means and who are supposed to have no other place in which they can receive a proper examination and appropriate and adequate treatment.

Dr. Henry S. Pritchett, acting president of the Carnegie Corporation, has said: "Somebody must sweat blood with gift money if its effect is not to do more harm than good."¹⁰ When he made that statement, did he foresee the establishment of the ——* Pay Clinic?

*Name of clinic purposely omitted.

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TUBERCULOSIS OF THE HIP IN CHILDREN; PATHOLOGY, SYMPTOMS AND DIAGNOSIS*

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Pathology—Changes in the bones and joints rarely represent the first foci of infection, or the primary lesion. As stated by Much, there are two possibilities of their development: (1) Through a trauma or other injury a lesion of tissue. Dissemination of tubercle bacilli from the bronchial glands into a "locus minoris resistentia;"

*Read before the staff of the Pine Rest Sanatorium.

(2) Trauma. Deposition of bacilli, which are circulating in the blood current. Living bacilli are not alone found in the blood patients with an advanced, but also with a light infection, and also in the blood of clinically healthy beings. They come from some foci, or from the outside, and are rendered harmless in the majority of cases by the defensive forces of the body. In a damaged tissue these forces of defense are defective, and, therefore, the bacilli are able to settle there. He concludes by saying: "The previous damage to bones and joints may, of course, be due to other causes, but in any case it is a necessary supposition." The generally accepted theory is that the tubercle bacilli lodging, as they usually do, on their first entrance into the body, either in the cervical, bronchial, or mesenteric lymphnodes, lead there a peaceful and usually overlooked existence. They may, and probably do, from time to time, if these nodes caseate and rupture, escape into the general circulation, but usually perish, because in their journey they find no suitable soil for their continued existence, and if all goes well, they may not give evidence of their existence until adult life. But if anywhere in the body there is a place of lessened resistance, the bacilli in their journey, eventually reach this area through the circulation, and, finding surroundings suitable for their existence, establish themselves in a new home and thrive, and, quoting the words of Asthurst: "They occupy the land, and, like the patriarchs and their progeny of old, become as sea sands in multitude." In 1911, Ely pointed out that the most favorable soil in bone for the development of tubercle bacilli is one where lymphoid cells exist, such as in the synovial lining of joints; or red bone marrow, as exists in the cancellous ends of bone, in children; and in the short bones of the carpus and tarsus. It so happens that emboli of tuberculosis may occur in all parts of the body, but, except in favorite localities, the bacilli will not survive; and even in favorable soil they may not survive unless the natural resistance of the part is already damaged.

It is thus that you find in about one-third of cases a history of trauma, usually comparatively slight, preceding by a period of several weeks the development of symptoms of tuberculous disease. Thomson, of Edinburgh, states: "The large majority of the cases of tuberculous disease of the bones and joints met with in Edinburgh are due to the bovine type of bacilli (62 per cent.),

and are, therefore, presumably carried by the tuberculous milk." His explanation of the pathology is as follows: "A history of some injury, usually a trivial one, is often given; and what probably occurs in these cases is that a small vessel, the walls of which have been weakened by endarteritis, is ruptured and extravasation takes place. The tuberculosis in the extravasated blood proceed at once to form tuberculous follicles; and before long, caseation has begun in the center of the mass and fibrosis at the periphery. If the caseation predominates, the disease tends to spread rapidly (infiltrating tubercle), while if there is much fibrosis, the disease remains localized (encysted tubercle). An injury to the bone in which there is encysted tubercle may lead to the development of the infiltrating type." The injury which precedes the tuberculous joint symptoms rarely is severe. Fractures scarcely ever are followed by tuberculosis, and fractures in the tuberculous heal normally. Two explanations are offered for this; one is that the more severe injury arouses better defensive action on the part of the patient; the other is that severe lesions require careful and prolonged treatment, and healing, therefore, is more apt to occur than after a trivial injury, which often is neglected. Oftentimes the parent will bring the child to you complaining of pain and disability, and this type of pain is usually the referred pain. Many are treated symptomatically for weeks and sometimes for months for pains in their stomach, when a cursory examination of their back, demonstrates tuberculosis of the spine, and proves that the abdominal pain was merely pain referred along the intercostal or lumbar nerves. So, too, with disease of the hip-joint, the pain may be referred to the knee, or to the anterior portion of the thigh, just above the knee, along the obturator nerve, and all the embrocations and liniments which for weeks have been applied to the knee have been unavailing. Stiffness of the joint may have been noted by the parents for some days or weeks, apparent when the child first gets up in the mornings; such indisposition of the joint often wears away during the day, but towards evening the joint again becomes disabled, and this is evidenced by a slight limp and complaints of pain. Pain may be almost absent, except when a joint is used; but frequently a joint which is painless, when the child is awake, will cause trouble at night, causing restlessness; and on falling

asleep and relaxing its muscles the child will experience sharp pains, which will momentarily arouse it from sleep with the so-called night cry. Accompanying these symptoms there is usually a slight constant elevation in temperature.

Symptoms and Diagnosis—(It goes without saying that children suspected of tuberculosis of the hip should be examined stripped; as nothing hinders so much proper appreciation of deformity or limitation of joint motion as the presence of clothing). The first symptom, as a rule, is a slight limp, due to spasticity of the muscles (hip), which causes the child to step short. The onset of the disease is very gradual, and the limping may disappear for weeks at a time, and return again, and again disappear. Pain in the anterior portion of the thigh, just above the knee, is an early symptom. A shortening of the gluteal fold, and a general flattening of the hip, with an increased prominence of the trochanter are characteristic of hip disease. (Cause of deformity, flexed and abducted hip.) The tendency to spasticity of the hip muscles furnishes a most valuable aid in diagnosis. There is a general limitation of motion as compared with that of the sound side; abduction, adduction, flexion, extension and rotation are all restricted. The joint appears fixed, and distinct muscular rigidity is shown if efforts are made to move the diseased hip. At first this is seen only during backward extension, with the child on the abdomen or side, but later motion in any direction is restricted, and with the patient on his back, the pelvis may be found to move with the leg, if the fingers are placed on the anterior, superior spinous process of the ilium. Swelling and tenderness about the joint may be detected even early in the course by feeling for the head of the femur under Poupert's ligament, close to the femoral artery. Atrophy of the thigh begins early. The suffering from movement may become so decided that walking is impossible, or accomplished with a very marked limp; and even when at rest the pain is often very constant and intense. When the child is on its back on a table, the legs extended and parallel, the diseased leg now exhibits an *apparent* shortening, owing to the tilting of the pelvis upward, and the back is arched. Destruction of the joint proceeds, with the production of pus within it, the swelling about the hip increases, and an abscess may form, with fluctuation and finally discharge. This

evacuation is oftenest immediately in front of the joint. It is to be remembered that absorption of the head and neck of the femur may occur without any visible evidence of suppuration. In this advanced stage there is *actual* shortening of the limb, as shown by measurement from the anterior superior spine of the ilium to the internal malleolus. A very marked lordosis of the spine develops. The constitutional symptoms vary. In the early stages there is restlessness, irritability and sometimes a slight rise in temperature at night. Later, with the formation of pus, the fever may be more decided, but may fall when discharge takes place. The diagnosis should be made as early as possible, and is based upon a consideration of the symptoms described, including a careful examination of the child undressed, walking, standing and recumbent. Of prime importance are the development of a limp, the reflex pain, the position of the limb and the muscular rigidity, as elicited by passive motions. Radiography is of inestimable value, the joint early appearing indistinctly outlined, and in advanced stages showing undoubted evidences of destruction of the bone and of faulty position.

Rheumatism is often suspected, but this is seldom confined to one joint, and is of acute onset, with fever and with localized swelling and pain. *Spinal caries* may produce flexion of the thigh from the production of a psoas abscess. The restriction of movement is generally, however, limited to extension. *Trauma* of the hip causes acute local pain, swelling, lameness and even suppuration; but the onset is acute after injury and there is no muscular rigidity. An *infectious arthritis* is acute in nature and rapid in its course. The referred pain of hip-joint disease may suggest the existence of tuberculous arthritis of the knee-joint, but examination will readily show the absence of involvement in this region. *Juvenile Osteochondritis Deformans* (Parthe's disease) is a rare condition producing symptoms very similar to those of tuberculous coxitis. It is distinguished, to a certain degree from tuberculous of the hip, by the lack of pain and spasm; the limitation of motion, chiefly on adduction; the absence of evidences of rarification of the bone on x-ray examination, the negative Pirquet reaction. (Six cases found by Delitala out of fifteen hip cases). The symptoms and physical findings in cases of *syphilis* are quite similar to those of tuberculous coxitis; but can be ruled out by a negative Wasser-

mann reaction, the history; absence of luetic stigmata, assisted by a positive Von Pirquet. *Growing pains* and *abdominal conditions* are to be thought of as well. *Congenital Dislocation* and *Coxa Vara* can be ruled out by the xray. In congenital dislocation, additional data can be obtained by the history, the gait and by Trendelenburg's sign, elicited by having the child stand on one leg, in which case, when the opposite leg is lifted, the pelvis is tilted downward, if standing on the dislocated leg, and upward if standing on the sound leg. The difficulty in diagnosis of hip-joint disease, even in the early stages depends chiefly on lack of care on the part of the examiner. In the later stages a mistake is not often possible. An early diagnosis is of the utmost importance, as the outcome in tuberculosis of the hip is in direction proportion to the earliness of diagnosis.

LESIONS OF THE CHEST MOST FREQUENTLY MISTAKEN FOR PULMONARY TUBERCULOSIS*

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In institutional work, if one is on the lookout, certain types of lesions in the chest stand out as being most frequently mistaken for pulmonary tuberculosis. There are other conditions to be noted besides those mentioned in this paper, which are misleading, but as we wish to portray our own experience, these are intentionally omitted. The general conception of tuberculosis is one of an early or an advanced lesion. We have, therefore, thought it best to divide the series into those lesions mistaken for early, and those confounded with late pulmonary tuberculosis.

Among the lesions frequently mistaken for early tuberculosis, the one which stands out most vividly in our experience, is that of a sub-sternal thyroid, with hyperthyroidism. The symptoms: Temperature, between 99 degrees and 100 degrees Farnheit; high and unstable pulse, sweating, loss of weight and strength, anorexia and short, hacky cough, on the surface, do most emphatically resemble early tuberculosis. In conjunction with these symptoms we have signs, due to pressure, which, especially if found at the left apex, lead one

to think immediately of the infiltration of early tuberculosis. Xray examination, both by plate and the fluoroscope, feeling of the mass behind the sternum, when the patient is placed in a modified Trendelenberg position, fine tremor, especially on excitement or exertion, nervousness, tachycardia on excitement, in the presence of no or negative spurum, should make the diagnosis. The tuberculin reaction may or may not be positive.

Congestion of an apex, following a grippal attack or an influenza, is commonly diagnosed as incipient pulmonary tuberculosis. The patient gives a history of having an influenza or an influenza-like attack, which has as a sequel a persistant, hacking cough, with a small amount of mucoid sputum, negative for tubercle bacilli. This may cling for months and will eventually lead the patient to a physician for an examination. The examiner will find signs at an apex and will frequently send him to a sanatorium for treatment, breaking up the home, and often cause the patient to lose a good position, besides having the stigma of tuberculosis placed upon him. The patient probably has no other symptom aside from this slight cough and expectoration. The physician has been taught that tuberculosis of the insidious type of onset is frequently mistaken for influenza. The fact that the sputum is negative for tubercle bacilli does not definitely prove the case to be non-tuberculous; there are a few rales present on inspiration, therefore, the patient must be tuberculous. A careful study of the history, the lack of symptoms aside from hacky cough and mucoid expectoration, the general good physical condition of the patient, and a careful bacteriological examination of the sputum, including culture and guinea pig injection, will show that the causitive organism is one of the cocci or the influenza bacillus, instead of the tubercle bacillus. The study of stereoscopic xray plates help to differentiate this condition. Autogenous vaccine should help to clear up the diagnosis, as well as the lesion. Tuberculin reaction is, as a rule, negative.

Collapse atelectasis completes the trio, which, in our experience, are the most frequently diagnosed as early tuberculosis. In dispensary practice and where routine lung examinations are made,

*Read at the October, 1922, meeting of the Bayonne Medical Society.

cases frequently arise, which show up fine rales on inspiration in one or both apices. No other sign is demonstrable, except possibly some very slight change in the percussion note, especially made out if percussion is repeated after auscultation has revealed the fine rales. The patient either has no symptoms or has those arising from other organs. The condition arises, especially in patients with sedentary occupations, where deep breathing is not practised, in those who do not know how to breathe properly—there are many such—and in people with chests fixed by early ossification of the costal cartilages. A more careful examination, using expiratory cough (cough at the end of forced expiration) will, after a few trials, make these rales disappear. Not only that, xray examination will show both apices to be perfectly clear, lighting up beautifully on inspiration under the fluoroscope.

Lesions mistaken for late tuberculosis might be divided into two classes; the first being lesions outside of the lungs, and the other being non-tuberculous lung lesions. Of the lesions outside the lungs, the most important is aortic aneurysm. Some aortic aneurysms and dilated aortas give practically no symptoms to give us a clue as to the diagnosis. By their size they produce pressure on the bronchi, and signs which might indicate any lesion from infiltration to cavity formation, develop. Moisture is produced by retention bronchitis, and we find lungs full of large and medium coarse rales. As a rule, there is no fever, but this retention bronchitis may become fetid in character. Absorption of this material will raise the temperature. Many of these cases are never diagnosed properly during life. At the autopsy our surprise and chagrin at the mistake we have made is marked, to say the least. The one clue that we have, that this case might not be tuberculosis, is the fact that we have a tremendous quantity of sputum in an apparently active, far advanced case, in which no tubercle bacilli are found. Large quantities of sputum from apparently active cases, containing no tubercle bacilli, should always put us on our guard to make repeated and thorough examinations and investigations. Since the days of the use of the xray in the diagnosis of chest lesions, mistakes are less liable to occur than formerly. The xray

should show up this pulsating tumor in the mediastinum. In those aneurysms which have typical symptoms, no mistake should be made. Nevertheless, it is not an infrequent occurrence, especially among negroes, to find such aneurysms, sent into sanatoria, with a diagnosis of far advanced pulmonary tuberculosis. Tuberculin reaction may be negative. The Wasserman reaction, as a rule, is positive.

One other type of lesion outside the lungs is frequently mistaken for pulmonary tuberculosis. That is, tumors of the mediastinum. These may be benign or malignant. The xray examination will show an enlarged hilus shadow, with most of the lung clear. Cough is probably the most marked symptom present. This cough is most usually of the harsh, "brassy" type and is non-productive. If there is any sputum present it is mucoid in character and small in quantity, negative for tubercle bacilli. Pressure may produce retention bronchitis, with its characteristic sputum and symptoms. The albumen content of such sputa is small. The other symptoms depend upon whether we have a malignant or a benign condition present, and the extent of the retention bronchitis. The tuberculin reaction here is liable to be negative.

When we consider the pulmonary lesions mistaken for tuberculosis, our problem becomes more complex. These lesions may be separated into two types. The most frequent type here is that in which the lesion, because of location or pathology, is markedly different from tuberculosis. The other is produced by organisms of the streptothrix type or by various dusts, as iron, lime and coal, etc. The lesion here is indistinguishable from pulmonary tuberculosis, and only careful study will differentiate the two conditions.

Among the first type of lesion we can mention chronic lung abscess, bronchiectasis, malignancies and other lung tumors, and syphilis of the lung. When we have a case that has a large quantity of purulent sputum, in which the condition has lasted a long time, sometimes giving the history of a rather acute onset, the signs showing up anywhere but at the apex, with a clear lung on the opposite side, and having no tubercle bacilli after repeated examinations, it is time to look for some other cause than

tuberculosis. The case is probably one of lung abscess. The sputum may or may not have a fetid odor. The temperature has short periods of jumps to 100 or 101, with more or less prolonged periods of normal. Blood spitting is not uncommon, and even frank pulmonary hemorrhage might be present. The xray shows a rather dense shadow on one side, the apex lighting up fairly well under the fluoroscope, with a clear lung on the opposite side. The fingers may or may not be clubbed. The tuberculin reaction is probably negative. The signs indicate a consolidation of the part affected. Sometimes signs of cavity are made out.

True bronchiectasis is more common than the average textbook would allow one to believe. Here we have a long-standing condition, with cough and a rather fetid expectoration, as the main symptoms. Morning sputum comes up in large quantities; up to six or eight ounces. It is negative for tubercle bacilli. For the length of time elapsed in the history, the general physical condition of the patient is good. The fingers and toes are clubbed. There may be periods of blood spitting, but frank hemorrhage is rare. The signs are extremely indefinite, the only departure from normal being, at times, slight dullness at a base, with somewhat distant breathing. Rales are not often encountered. The xray usually shows a dense shadow at a base. Stereoscopic plates, at times, will show up a sausage-shaped cavity, but not very often. The other lung is clear in most of the cases.

Malignancies of the lung take on the form of some types of pulmonary tuberculosis, though they do not as a rule affect the apices. The diagnosis may be made from the general physical condition of the patient. The temperature curve is not typical. It is more often normal than is a like quantity of active pulmonary tuberculosis. At times, as in sarcoma, it may be high. There is marked pallor. Fingers do not often club. The one clue of importance is blood spitting, not frank hemorrhage, over a protracted period of time. The sputum is negative for tubercle bacilli on all examinations, including guinea pig inoculation. Such a case should have the sputum gone into thoroughly, making examinations of fresh smears, as well as staining the slides with vari-

ous tissue and blood stains. All strage cells should be carefully studied. It seems that endotheliomata are the most frequent. The sputum in these cases will show typical endothelioma cells. Where there is a history of malignant disease elsewhere, the probability of metastasis should not be forgotten. Fluid, serous or sero-sanguinous, is not uncommon. Xray examination will show a rather dense shadow. In metastatic carcinomatosis there is some chance that the plate will be more nearly that of a broncho-pneumonia.

Syphilis of the lung has lately come to the fore as a condition mistaken for pulmonary tuberculosis, most frequently found in sanatoria which have a large proportion of negro patients. Here, as we find it, is a far-advanced lung lesion, with the most prominent signs of consolidation, frequently in the left lung, between the second and fourth ribs. When associated with symptoms of secondary syphilis, hoarseness, loss of weight and strength and anorexia, there is sufficient reason for thinking of pulmonary tuberculosis. Cough and expectoration are present, but the sputum is negative. Tuberculin reaction may or may not be positive; however, the Wasserman reaction should be positive. Under specific treatment, the lesion clears up beautifully.

Lung lesions produced by the various dusts, as siderosis, calcicosis and anthracosis, are mistaken for chronic fibroid tuberculosis. The symptoms are usually cough and expectoration and marked shortness of breath. Fever is not a necessary factor, but is present at times. The signs are those of a disseminated fibroid infiltration, and sometimes consolidation, usually affecting both lungs. Both the signs and the xray findings are such as to make a differential diagnosis for us. Tubercle bacilli are absent. The examination of fresh, unstained specimens of sputum should disclose crystals of the causative agent. The history is of great importance.

Lesions caused by the streptothrix group of organisms are the most difficult to differentiate from pulmonary tuberculosis, and are most frequently diagnosed as such. The lesions are akin in the gross, with physical signs, xray shadows and location the same. The symptoms are practically identical with those of tuberculosis. The only differen-

tial points are the presence of the organisms in the sputum, found after careful and prolonged search, and the reaction to a preparation of dead organisms. This test is made after the manner of making the tuberculin test. The streptothrix is acid-fast and may be mistaken for the tubercle bacillus.

Chronic bronchitis and emphysema furnish a goodly number of our errors. The patients are usually older than the average tuberculous individual. They appear well nourished, though they complain of inability to earn a living, because of cough and expectoration, some weakness and shortness of breath. The history of long-standing disease, with periods of well being, though there are no definite periods of real tuberculous symptoms, the negative sputum and the physical signs, which seem to change at every examination, should put us on our guard.

We offer this paper with the hope that more careful examinations and study be made of suspected pulmonary tuberculosis, which have sputa negative for tubercle bacilli, and that more frequent examinations of the unstained specimen be made. We would like to present this axiom: Cases having advanced lesions, with moderate to large quantities of sputum having no tubercle bacilli on thorough, repeated examinations, should be considered non-tuberculous until all means of diagnosis at hand have been tried and considered.

MENTAL HYGIENE; SOME OF ITS MORE IMPORTANT ASPECTS.

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Mental hygiene is that branch of medicine which has to deal with the preservation of mental health, and the avoidance of mental disorder. Great progress has been made during the past two decades in what was formerly a neglected branch of the medical sciences.

We should be frank to refer to mild mental disorders as such, instead of calling them "functional nervous diseases." The difficulty lies in the fact that the minute you speak of anything being "mental," the public conjure up a picture of some grave form of insanity. So the

persistence of our referring to many mild mental upsets as "nervous diseases" is due to a euphemistic conciliation on our part to the wishes of the laity. Hysteria, for example, is really a mental and not a nervous disorder. Yet if the physician were to so designate it, he would very possibly lose the patient. For the average patient regards with disfavor any reference to his or her being "mental." Of course, where there is an organic cause for the mental disturbance, the organic disease receives primary attention. And here we might say that there should be no stigma attached to a mental upset, for people who thus suffer are usually of the higher intelligent class, and usually very ethical. Individuals of the lower type and criminals seldom suffer from mental upsets.

Some of the aims of mental hygiene are to keep body and mind in harmonious working order; to avoid unnecessary stress and strain and needless worry; to get the individual to really know himself and to learn how to supplant persistent dissatisfaction by contentment; to be useful not only to himself but to society; to direct him to that profession or industry where work is satisfactory and becomes a pleasure; to learn how to follow the standards of the herd (i. e. society) comfortably, and at the same time to gratify his own wishes in a socially approved way; and by no means the least of all, to develop a happy emotional tone in his family life.

Arthur Pound, writing in the Atlantic Monthly, says of the average normal citizen that he "is a dependable being, capable of taking care of himself and his family in ordinary times and not too complicated situations, fairly adaptable," . . . and who, after the first flush of youth, drifts into "a steady, plodding citizen, more prone to excitement over little things than to thought over fundamentals." If such an individual avoids undue stress and strain, feels fairly contented, and is honest with himself, he need never have a mental upset. Conversely, if he is continually dissatisfied and discontented with a vital situation in his life, from which there is no ready escape, as working in an unsuitable or unbearable environment, or being married to an emotionally displeasing mate, etc., he stands a good chance of developing numerous mental symptoms.

Mild mental disorders are very common. In fact, it is quite correct to say that a large part of every physician's practice has to deal with them.

Centuries ago, insanity was ascribed to witchcraft or various metaphysical causes. Later it was said to be due to various diseases of the organism. Though this showed progress, yet this idea presupposed the presence of some physical disorder or defect, which, however, could rarely be found on examination. The earlier psychology was content to rest the whole question by merely noting that there was a defect of will, or judgment, without troubling itself about carrying the analysis any further, to get at ultimate causes. The modern psychological method of approach gives one real understanding of a patient's difficulties. For every thought and every act has its reason for being. They do not occur by chance.

Where a prolonged, unusual reaction, between an individual and society is present, and certain other mental factors are present also, we have to deal with mental disorder. "Normal" means customary or usual. Normal people react along definite lines; whereas abnormal people, because of improperly controlled or badly directed mental material, react in eccentric ways. We refer to this type of person as one who has certain bad traits or trends. A trait is a characteristic; a trend is the habitual way one exhibits that characteristic. We teach that a study of a patient's traits and trends is of prime importance, of greater value for future advice than a mere superficial study of his present state of irritability. Being "nervous" really means being irritable.

A few of the more common bad traits and trends, which, if in excess favor mental disquietude, are: A feeling of inferiority; being too distant and abnormally serious with no sense of humor; being too sensitive and touchy; being over-suspicious and abnormally seclusive; selfishness; marked indifference to the ordinary interests of life; undue dependence (affective) on the family; being generally discontented and dissatisfied; resentment; offensiveness toward others. There are numerous others, of course. A combination of certain of these traits and trends, with an individual's adaptability toward reality and the environment, and

thus naturally lessens efficiency, and retards success. The resulting brooding represents a damming up of the feelings, and indicates unhappiness. A happy person, with numerous satisfactory outlets for his feelings, has no occasion for brooding. Bad traits and trends can be modified, even in those cases where they cannot be fully corrected.

The reactions of all people differ, and they are in great part determined by the individual's character traits and trends, i. e., by the mental stuff they are made of. This applies to mild states, as hysteria, or grave ones, as the various forms of insanity. In estimating the value to be placed on a particular trait, it is absolutely essential to determine whether the trait is a genuine one, or a compensatory one. Goodness and prudishness, for example, are not synonymous. While the reactions of individuals differ, yet in some respects all people have certain characteristics very much alike. The desire to forget the unpleasant and remember only the pleasant is a fundamental characteristic in all people. Certain pseudo-medical cults have taken this psychological fact as a starting point—"Christian Science" for example—and have tried to develop a philosophy out of it. In fact, the same might be said of all queer cults; that they begin with a kernel of truth, to which they add a mountain of fraud.

The Emotions.—The study of the emotions (i. e., affects, feeling or sentiment) is of paramount importance if we would properly estimate the causes and later correction of abnormal thought and conduct. The emotions are divided into (1) the egoistic or selfish ones, as fear, anger, self-love, etc., and (2) social feelings—as love for others, sympathy, respect, reverence. Then we have the sentiments—intellectual (curiosity), aesthetic, and moral (feeling of obligation). In former days, in studying a case of mental disorder, we reviewed carefully intellectual anomalies and queer acts of the patient, without considering sufficiently the dynamic or driving value of the emotions. It is quite true that normal emotional balance in great part depends on a healthy body, not only in an organic sense, but in a functional sense as well. A person mentally tense is probably in greater part tense also throughout his whole vegetative domain.

I might repeat that the instincts and emo-

tions are of greater determining value on conduct than the intellect; the latter exerting chiefly a discriminative or restraining influence. It is a difficult thing to estimate the emotions in terms of capacity. Man is continually seeking outlets for his emotions. Fear and anger appear early in the mental development of the child. Whether we have a reaction of flight or one of aggressiveness depends on the character of the individual. However, where the genesis of the fear—or better morbid anxiety—is unknown (as fear of crowds, of high places, of travelling in underground passages, etc.), then the patient is unable to attack rationally and intelligently, and reacts with various nervous symptoms, and with tenseness or fatigue. A habitual damming up of the emotions, because of insufficient outlets, results in mental upsets characterized by restlessness, depression or excitement, or even the development of dual personality. A tense person who fights against his difficulties soon develops fatigue, as a constant symptom. Needless to say, you cannot cure these individuals merely by removing a few teeth, putting them on a protein-free diet, giving them pituitary extract, etc.—enthusiasts to the contrary notwithstanding. Neither can you cut out a mental condition by surgery. Re-education and mental re-adjustments are necessary. A study of the patient's repressions would be more fruitful. And electricity may amuse this type of patient, but it will not cure him.

Where the adult patient's interests and his manner of expressing his feelings show he is focused backward to an earlier period in life (youth, childhood, or even infancy), we have to deal with what is called a regression. Where this condition persists for a long time we are dealing in most cases with the most common of all mental disorders, dementia praecox. Much peculiar behavior is merely a compensatory reaction to the patient's profound feeling of, or fear of, inferiority along certain lines. Industrial misfits are usually unhappy and unsuccessful, and discontented and irritable. The cause of their mental symptoms is not always the same. Where a worker feels he is underpaid and badly treated he lacks interest, and, of course, incentives to do better work. His problem is quite unlike that of the worker who may be suffering from an early cerebral arteriosclerosis or an incipient dementia praecox. Yet they may all complain more or less of the same symptoms at first. So we will emphasize again that a study of the patient's present

difficulty, without an estimation of his character traits, would be a futile task.

Every individual should know his capabilities and his limitations. For a man to refuse to acknowledge that he has limitations, or for him to persist at a task where failure is inevitable, is merely to invite a mental upset. "Nothing succeeds like success," for the simple reason that success is an expression of power in some form, and all normal people crave power and security. Fearing a loss of the sense of security (financial, social, love), is a potent cause in producing mental symptoms. People whose instinctive wishes are gratified or neutralized in a socially acceptable way will not develop a neurosis. When we speak of a person being tense, that must not be taken as a pure figure of speech. A person who is mentally tense, is bodily tense—proven by numerous signs and symptoms, referable to the vegetative or autonomic nervous systems. In such cases it is not uncommon to see a high blood pressure without any evidence of disease of the heart, arteries or kidneys. Personally, I believe many of the cases designated as "essential hypertension" belong here. How often do we see these cases of high blood pressure drop to normal, when the emotional state (tension) becomes calm and stable—and without the aid of vaso-dilators, saline catharsis or a protein-free diet.

The Child and the Family.—The mental development of the child and its relation to the family are given considerable study by all students of mental hygiene. It has been conclusively shown that the five years of the child's life are the most important years of all, from a psychological standpoint. During this period are formed the genuine traits and trends, which become the adult habits. Later in life these traits and trends are strengthened and also compensatory traits are added. The later compensatory ones may be useful—to change useless characteristics into socially useful ones. Others, of course, are developed to make a good impression on the public. The wish for public esteem is innate. But the public does not always estimate correctly. We might say that conduct is what one does for himself and his own ideals, while behavior is what he does for the consideration of the public. Likewise we might say that character is what we really are, while reputation is what the public thinks we are. The mother is the particular object of the young child's affections, not only because she represents to the child nourishment and protection, but because

sympathetically she can always be relied upon—the father only sometimes, when he is not busy with other things.

Parents must not stress too much how good they have been to their children. Because the child, who joins the parents to immortality, is also a source of much pleasure to the parents. And parents, if they will have mentally healthy children, must bring them up for the children's own happiness and future interests, and not for any selfish motive of the parents. The attitude of the parents—more than anything they say—is the greatest determining factor in the mental development of the child. For this reason a child brought up by an emotionally normal mother has a most auspicious beginning for a happy, successful career. Certain types of men and women are temperamentally unfitted to be parents. The past century has been the greatest one in regard to the emancipation of women. However, for woman to fulfill her biological destiny and to reign supreme over the home is still her greatest honor and privilege. Spoiled children, particularly "only" children, who crave an excess of attention and sympathy and who have not had the controlling influence that the presence of other children exerts, are often difficult problems in later life. Their narcissism often develops into abnormal selfishness in adulthood. It is a fatal mistake on the part of parents to infer that children will "grow out" of such bad traits, as selfishness, lack of sociability, etc. Children react almost immediately to their feelings, using but little deliberation and almost no critique. In this respect some adults resemble children.

While it is true that parents must correct young children in order to civilize them, they must never be subdued harshly. For it destroys their initiative, and by emphasizing their deficiencies, it may lay the basis for a feeling of inferiority. Where a father is unnecessarily domineering and the son submits against his own instinctive wishes, he may become a neurotic or a weakling. If the son takes an antagonistic attitude toward his father, he may later in life be against all authority, become arrogant, over-suspicious, and even develop ideas of being oppressed by everyone. This is just the seed to develop a paranoid personality. Chronic insanities do not result by chance, but develop out of bad character traits, stresses, strains and conflicts. Conflicts lie at the root of mental life. A conflict is the battle between the selfish wrong wish and the social right course. A

study of the lives of Darwin and Guiteau are interesting in the light of the preceding statements.

In the management of some so-called "nervous" patients, the physician will not get results, unless he also treats one or more of the other members of the family. For in these cases we invariably find another member of the family acting as a repressive influence on the patient. We hear so much of family love and so little of family discord, and yet family feuds are often bitter, destructive and frequently irremediable. Children should not be brought up to abnormally fear their parents. For it is a psychological fact that what children fear, they dislike. This dislike is repressed, because of education, religious teachings, etc., but it has a great effect on the character of the child.

Marriage.—At the time of adolescence, the child must be taught to become affectively independent of the parents. For if the youth—the young man or the young woman—is so bound to the family (have a "fixation," as we call it), as to take no interest in outside people or events, anomalies of character are sure to develop later. One must not confuse normal family love, which is a stimulus to succeed, with family fixation, which dwarfs and eventually often ruins the individual. Such individuals with an abnormal attachment to their families often do not marry. If they do, they are continually returning, at least, in phantasy, to the safety of the parental roof. The son from such a family finds it difficult to find a woman of sufficient interest—i. e., emotional value—to marry. If he should marry, he selects as a partner a woman who possesses more the traits of a mother than a wife. Parents make a mistake to foster this fixation. It at least creates jealousy, and is the basis of the time-honored mother-in-law conflict.

Where one or both partners to a marriage are emotionally dissatisfied, it requires a great deal of re-adapting and re-adjusting to keep the union intact. Where the individual develops a neurosis, under such circumstances, one can readily understand why we so frequently hear of the complaint of lonesomeness. Most of the mental upsets we see are in adults, because conflict and instinctive worries are not characteristic of childhood. Nor are children bothered by stresses and strains. The importance of marital disharmonies in causing mental reactions must not be underestimated. Marriage is an ideal state, and the pinnacle is reached by too few. Sometimes

one feels that there should be more mutual interest and real comradeship and less self-love displayed.

The neurotic businessman struggling against a dislike for a frivolous wife will react with fatigue, headache, constipation and other signs of vegetative nervous irritability. But in coming to the physician, he will not attribute his troubles to his factor. Rather will he ascribe it—wrongly—to bad habits of eating, over-work, smoking etc. It is a truism that none is so blind as he who will not see. Continuous economic difficulties, cobined with an absence of relaxation, makes a difficult situation. For a man to remain mediocre, where the wife expected a very successful husband, and for a woman to be continually nagging a man who craves much sympathy, will eventually cause dissatisfaction and finally a neurosis in one or both. A woman who marries for economic or social reasons and has her wishes gratified, though not idealistic, will probably remain well, as she will justify herself. But the girl who marries for love and gets neither love nor a comfortable socio-economic status, has a good chance of developing a mental unrest.

It is disagreeable to say, and yet true, if not held in check by the opprobrium of the herd (society), or by religion, education, or the presence of children, etc., some married people would choose to return to a life of so-called freedom. And yet the married state itself cannot be entirely blamed. For while many find it difficult to adjust to the exigencies of married life, many others are bored by a life of single blessedness—particularly when they reach the thirties and forties. Still one need not agree with the pessimistic advice which Socrates gave to a young man in doubt about entering matrimony. He told him not to worry too much, as he would be unhappy no matter which course he followed. But marriage would not be such a problem if each partner would try to first know him or herself, and then would study to gratify the wishes of the other. It is a game of give and take, and the happiest ones are those who get more pleasure in giving than in taking.

Sex.—I will say just a few words about the sex instinct, which psycho-biologically is of the highest importance to man. For the best interests of the group or herd (i. e., society), culture demands its repression within narrow limits. The energy thus repressed must then be utilized through other channels. All individuals are not equally

successful in comfortably repressing this instinct. However, the dictates of society in this respect are logical, because of the accrued benefits to the race and civilization, resulting from this sublimation or substitution. It is true that certain individuals suffer, but the wishes of the herd must always take precedence over the wishes of the individual. Else we would have a society as chaotic as it witnessed in Russia today. This dictum holds true against the indiscriminate dissolution of marriage. Free divorce might satisfy the individual, but it would be bad for the children and society.

It is almost impossible to get people to agree as to the proper management of sex problems. Most people react to sex, either prudishly or vulgarly. It must be kept in mind that the physical side embraces only a small part of this impulse. The affective side among cultured beings is by far the most important element. Take the question as to what to teach children about this question and at what age. If they are not taught certain, simple facts by their parents or competent teachers—and the attitude and not the sex of the teacher is what determines competency—then we all must agree that they will learn much on the street and in school that is harmful. Parents should not teach them by set chapters, but rather should be guided by the questions of the child. And the serious questions of the child must not be answered in a flippant manner. Neither parents nor teachers should degrade sex before children, else they are favoring the development of later abnormal attitudes on the part of the children. Fear may inhibit or distort the adult expression of this impulse. It is said that most people show a certain amount of indignation against the expression of anything relating to sex. However, in some respects, this indignation is compensatory rather than real, else we would see stronger protest made against the vulgar references and exhibitions seen in the theatres, movies, books and newspapers, etc., all of which is suggestive and stimulating to the impulse. This is quite opposite to the scientific management of the problem, whose aim is to inhibit direct expression of the impulse, and to direct the energy into socially approved channels.

Causes of Mental Disease; Heredity and Environment.—We have already referred to some of the causes of mental upsets. Numerous factors enter into each individual case, though the last and precipitating

cause may be the one stressed most by the family. Fear, particularly anxiety, hatred, conflicts over instinctive wishes and social obligations, disquieting family life, a loss of social esteem, economic worries, a continuous feeling of insecurity concerning the important relations of life, are—alone or in combination—potent causes for producing restlessness, irritability, depression, etc., with their mental and physical accompaniments. The subtle influence of an eccentric parent or grandparent on the descendants is very great—yet easy to trace. The following combination, for example, would almost certainly cause a mental upset in any ordinary person; a family fixation, narcissism, a colorless existence, with no strong incentives for success, persistent discontent and absence of any suitable outlet for one's feelings. There can be no question as to the relative practical importance of heredity and environment in mental hygiene. For, as far as the immediate present is concerned, we can influence only the latter. Again, it would be a fatalistic conception if you tried to explain every character anomaly on heredity, and it would not agree with the facts. It is not necessary to try to trace all good or all bad traits through the blood. Imitation through constant association is a quite sufficient *raison d'être*. The following will show how superficial must be our conclusions as to heredity. It is difficult to trace back at best more than a half-dozen generations. And yet if you will think of how many ancestors each one of us had, say a few hundred years before the time Columbus discovered America, it would greatly surprise you. Now as we think of time, that was not so long ago; it was about the time the Sorbonne was founded in Paris. At that time we each had about 2,000,000 ancestors. And a careful heredity survey will take into consideration at most a few dozen of these. It is not that I would minimize the importance of a good heredity—of good stock. But for the purposes of mental hygiene, moulding the environment is a much more important task. That child is most fortunate who has harmoniously mated parents; the child is bound to have a happy emotional status. Besides studying the heredity and the environment, the general physical and neurological status of the individual, particular attention must be given to the present upset and its precipitating cause. Defects in the education of the individual must be sought for. Many educators will agree that too much time is spent in acquiring much useless material

and too little time given to develop individuality—i. e., to strengthening certain valuable dominant traits.

Insanity.—I will not go into any detail concerning grave forms of mental disease, or insanity. The term "insanity" is one used more by the legal than by the medical profession. Probably nearly half of these cases are curable if properly managed in the early stages. Only where the patient shows a prolonged basic indifference, a persecutory trend, or is deteriorated, does one need to be unduly apprehensive. In most of the other conditions, one looks for a good outlook, particularly if the character traits are good. Neither excitement nor depression—no matter how profound—are causes for apprehension on the part of the relatives that the condition is hopeless. The fear of grave insanity unnecessarily haunts the minds of many patients suffering from mild mental symptoms. In fact, this fear is one of the commonest complaints physicians hear in the consulting room. -

There is one practical point I would like to mention of interest to the general public. It concerns the treatment of the insane. In suitable cases, where the patient is capable of making voluntary application for admission, the hospitals will receive them. Where commitment is necessary, the patients may be sent to a State hospital, or a private sanitarium. Our State hospitals today are renowned all over the world, for the efficient, scientific care they give this class of patients. Private sanitariums are more exclusive, of course, and are excellent for those who can afford them. The State hospitals have numerous buildings, which permit a discriminative separation of patients into various classes. Patients may be committed directly from their home to a State or private hospital without the need of going through an observation ward. Observation wards should only be used by the very poor, and for doubtful cases. They are detained in these wards for a few days to see if they are suitable cases to be sent to a mental hospital for care and treatment. When we speak of insanity, we do not include cases of original mental defect, commonly known as feeble-minded—of the three grades of idiot, imbecile or moron. The problem of the feeble-minded, unlike the insane, is an educational and custodial one—not a curative one. Feeble-minded people are those who were never well-endowed mentally, while the previous mentality of the insane was once quite normal. The one never had a

normal mind to begin with; the other had.

Treatment.—The treatment of mental upsets by drugs, massage, electricity or surgery has value in a limited way. But the real treatment to affect a cure is a mental one. Nor will the mere statement to the patient that he has no organic disease, nor the time-honored admonition "don't worry" cure him. Nor will a trip to the country do any good, if the patient has no interest whatever outside of himself, and refuses to co-operate with his relatives or physician. Nor will the continuous taking of "tonics," many of which are full of strychnine, cure him. In fact, in most of these tense cases, strychnine is contra-indicated. And a weak, depressed patient will be made worse by the long-continued taking of bromides. And only in very few cases does the indiscriminate taking of endocrine glands—the modern panacea—do any good. The wonders of endocrinology—a very speculative field—are as romantic as the tales of some novelists, if one would pay attention to some enthusiasts. The truth of the matter is that such claims are out of all proportion to our positive knowledge of the subject.

Unless you make the patient correct his present mental deficiencies, and handle his ethical and religious difficulties in a proper way, and make him learn how to dissipate his conflicts and be honest with himself; to learn to change his attitude toward certain disquieting situation—particularly family and social—and last, but not least, furnish him with some healthy outlets for his energies, you will not cure him. Thus we see why the Weir-Mitchell and other rest cures will fail more often than they cure. Rest and sleep, however, are often badly needed in these cases, for their continued anxiety is often exhausting. And here I might say, as to the value of hypnotics for insomnia, that hypnotics are bad—but persistent insomnia is worse—hence, for a time hypnotics may be necessary. The insomnia often persists through fear alone.

Stress and strain alone do not cause a prolonged "breakdown." Other factors, such as worrying, brooding, etc., acting on certain character types, must be present. This was well shown in the great war. Those of us who treated troops in France had less of these upsets to treat than the physicians attached to the French and British armies. The United States learned from the experience of France and Great Britain and rejected certain character types

as unfit to stand the strain of active warfare.

It is a well recognized psychological fact that to be mentally sound and happy, every adult must have an aim and object in life. Every human being absolutely needs the esteem of others. Where this esteem is denied or is not available—and how frequently we see such cases—then morbid traits and trends invariably develop. The physician will have failures in curing many of these cases, because of conditions beyond his control—as an impossible family environment, a disagreeable marital state, economic difficulties, etc.

I would like briefly to refer to two subjects of interest, particularly to those who treat nervous and mental patients. I refer to psycho-analysis, a valuable medical method in the right hands, and to quackery, which flourishes because of the credulity of chronic invalids, and their ignorance of problems of health.

Psycho-analysis.—This is simply a method to explore our unconscious mental life. And our unconscious is nothing more than our whole previous mental life. For those who would reject the theory, a rejection of the concept of an unconscious is sufficient. By means of psycho-analysis, we can get at the causes of many things not otherwise comprehensible. For example, the basis of prejudices, which are founded on feelings and not on reason; why certain men of education go into spiritualism, etc.; the causes of abnormal fears; the real reason why men marry the particular partners whom they choose; the reason why one who wishes to do the correct thing fears he will do the wrong one, etc. By means of this method we learn why certain patients lack the incentives to get well; whereas direct questioning (the old method) will give us no clue. And this type of patient, it might be said, is one of the most difficult to cure.

At first this method was not accepted by the profession. But this attitude has changed. The most severe critics were men who knew nothing about the principles involved, as is evident from their writings. Certain elderly neurologists—not psychiatrists—could not afford the months, or rather years necessary to master it, so they followed a false, though logical course. They minimized its value and rejected it. They thus were spared confessing ignorance, and incidentally saved their time. Most of our leading university teachers on mental diseases accept it as a valuable

method to study mental reactions—both normal and abnormal. A trained and critical mind is needed to form a proper judgment as to its applicability, especially in the treatment of mental disorders. Organic disease must first be eliminated. Next a careful study of the present upset, and an estimation of the character traits of the individual is necessary. For many patients should never be analyzed. Like all medical agents, it can do much harm if improperly employed—which is an argument against the operator and not against the method. Its practice by amateurs is preposterous.

It might not be amiss to say a word here about the treatment of mental patients by clergymen. They can be of much assistance to physicians. The emotional hold of the clergyman is greater than that of anyone else. However, this branch of medicine, like all medicine, does not depend for the successful management of disease on the emotions only. And the training of the clergyman does not enable him to recognize disease. Any mentally sick patient may also have a co-existing cancer, tuberculosis, or other serious organic diseases. And one not competent to eliminate all of these conditions, or to tell whether the mental picture is concomitant or sequential, should not undertake to treat the sick, for he is treading on dangerous ground. Lay analysts, with no medical training and no standing in our universities, medical faculties or hospitals, and who, unlike the clergymen, have no emotional hold on the patient, are an abomination. They are often dangerous, and can do much harm; for instance, by analyzing a patient who should not be analyzed. This may convert a mild disorder (as hysteria) into a grave mental disease (as dementia praecox). With no medical training they would not know how to differentiate a hysteria from a dementia praecox. Our lawmakers are very lax to permit these amateurs to deceive the public.

It seems quite the fashion now for anyone who has read a book on "mind-healing," or "character reading"—and who has no other visible means of support—to give lectures to the public on how to cure illness—rapidly. These pseudo-psychologists are flooding the country, and incidentally are giving a bad reputation to a reputable science. Modern psychology teaches that what we formerly called "will" really signifies "wish." A weak will-power is really interpreted as a weak wish on the part of the individual—one in which the person merely phantasies a situation—

the wish not being strong enough to drive him to action. A strong will-power connotes a powerful wish; one that is not content with phantasing a situation, but is aggressive and will not rest till the situation is won—i. e., the wish fulfilled. In other words, one fulfills the wish in thought, the other in action. The great importance of the dynamic value of the wish in human conduct is admitted by academic psychologists. Though they adversely criticize psycho-analysis, they admit that analysis first emphasized the importance of the wish (desire, craving, longing, or call it what one will) in determining reactions. We all spend our whole lives wishing, and working to gratify our wishes, conscious and unconscious. The socially acceptable fulfillment (and neutralization) of the wish leads to a comfortable emotional tone. The continued thwarting of a strong instinctive wish causes displeasure, tension, pain and mental illness.

Quackery.—In concluding, I wish to say just a word about quackery, which is of great importance to all students of mental hygiene, inasmuch as nervous and mental patients are the particular victims of those who practice fraudulent healing. Quackery is the pretension of medical skill or usefulness,—the pretensions not being borne out by the facts, nor by the experience of honest, scientific men. Securing the victim's money, of course, is the only motive. Even though an agent may have a slight value, if the value is purposely exaggerated for purposes of deception and gain, this also constitutes quackery. The prevalence of quackery in its various forms, and the financial success of those practicing it, shows a very superficial way of thinking on the part of its victims in matters concerning their health. The success of most forms of quackery is in direct proportion to the amount of advertising they do. The value of the agent advertised is of no great importance. There are certain quack cults which take one little idea which may have a modicum of truth in it, and about this develop a whole system of pseudo-medicine. The intelligent public would readily appreciate their ridiculous fancies and absurd assumptions, if they would only study them a little more closely than they are wont to do. Anyone who has had a good high school or college course in anatomy and physiology could readily see the absurdity of the claims of chiropractors. There is a cult called "finger surgeons" (who are not surgeons at all), who claim to cure blind-

ness and deafness by rubbing the eyes or throat. The whole thing is ridiculous; yet they have many victims. Another even more despicable cult call themselves "official surgeons." They belong to no reputable medical societies, and are a danger to any community.

The latest fad is the Coue' cure. Coue' is not even a physician, but a pharmacist. His method is to have you repeat over and over that you are getting better and better in every way, every day. Needless to say, a person who can cure himself thus, could never have been very sick. The danger here lies in the fact that a person with an incipient cancer, etc., would be losing much valuable time, while he was trying out this form of self-deception (euphemistically called auto-suggestion). Just as in war, the army is always trailed by irregulars, so in the war on disease, regular medicine will always have irregular followers, in the form of quacks, bringing up the rear. Considering their motives, they make one think of vultures. The law does not license them, nor does it do much to effectively control them. They appeal to a certain gullible type. By boldly crying out the "wonders" of their claims, they will always find victims ready to fall into their nets.

DIETETICS*

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After practising medicine for more than forty years, I am convinced that nearly all human beings shorten their lives by what they put into their mouths. No healthy baby born into the world, if properly treated from the beginning and barring accidents, should die before it is 125 years of age. Dietetics is no modern fad; it is one of the oldest things connected with medicine. Witness the following quotations from "Regimen Sanitatis," published over 1,000 years ago:

"Doctors should thus their patients' food revise:
"What is it? When the meal? And what its size?
"How often? Where? Lest by some sad mistake,
"Ill-sorted things should meet and trouble make."

And again:

"Eat not again till thou dost certain feel
"Thy stomach freed of all its previous meal.

"This mayst thou know from hunger's teasing call,
"Or mouth that waters, surest sign of all."

Many years ago, over 200, a French physician said: "One-quarter of what we eat keeps us, the other three-quarters we keep—at our peril." This may be slightly exaggerated, but the thought is a true one. Over-eating is a matter of habit, and very early in life the human stomach becomes relaxed, or stretched, so that by the time forty years of age is reached in perhaps 90 per cent. of human beings the stomach holds more than is necessary or natural. At the end of a meal we like to have what my good old uncle, Dr. English, of Englishtown, used to call "a comfortable sense of distention," and this would be natural and right if our stomach had not become so stretched that it holds much more than is good for us. The *normal* human stomach can always be filled so as to produce a comfortable sense of distention without harm, if it is not done too often. The trouble is we eat until we have an uncomfortable sense of distention, and do it often. The result of that is that there are very few human stomachs, at forty, that do not hold more food than is necessary or healthful for their owners. To eat until one has even a comfortable sense of distention with such a stomach is to eat much more than can be properly digested and assimilated. The residue rots and ferments in the colon, causing a chronic systematic poisoning which manifests itself in constipation, muddy skin, flabby tissues, stinking stools, early arterio-sclerosis and lack of energy. This state of affairs is brought about by bad habits. In a great many cases the bad habits are started in infancy, and due to too frequent feeding.

The feeding of infants is one of the most important matters in the world. Infants grows into adults. On how they are fed during the first twelve months depends very largely the kind of adults they will become. On the kind of adults they become depends the welfare of the whole world and the survival of the human race. It is much more important to rear an infant into a normal, healthy adult than it is to save the life of a man or woman over forty. To clearly understand the proper feeding of infants it is necessary to know the normal and pathological anatomy and physiology, and the chemical and mechanical action of the infant's stomach and intestines.

There are two things that should always be kept in mind: First, the infant is not merely a small adult, but is essentially a different organism from an adult, with a different anatomy and physiology, and governed by different natural laws; second, we are trying to help nature develop this infant into a normal adult. This means that whatever we do for the infant is not done for the present only, but also for the future. The kind of stomach and intestines that a man or woman of thirty or forty possesses, the value and efficiency of the adult, as a citizen, depends very largely on how he or she was fed during the first few months and years of life.

The stomach at birth is little more than a straight tube, hanging nearly vertically in the abdomen, continuous with the oesophagus above and with the duodenum below. It is elastic and easily distended, and it is in contact with and more or less pressed upon by the other abdominal organs and by the diaphragm. There is a slight fullness on one side of this tube, showing where the greater curvature and the fundus will be later. When over-distended it assumes a shape somewhat like that of the adult stomach. We do not know the exact size or capacity of the stomach of the newborn infant, but it probably holds about one ounce, or a trifle more. On account of its shape and position and the pressure of the surrounding organs its contents easily pass on into the duodenum, and this takes place even during feeding. This makes it impossible to over-distend the infant's stomach.

The adult stomach is essentially a muscle, lined with a peculiar mucous membrane, and covered with a serous membrane. This muscle is strong and active, rolling about the solid and semi-solid contents and separating them into different groups by zones of contraction. In the stomach of the newborn, this muscular coat is undeveloped and weak. The problem is how to make the undeveloped, weak muscular coat grow and develop into the strong, active muscular coat that should be found in the adult stomach. The development and functioning of the lining membrane will take care of itself if we succeed in making the muscle grow strong. We know that the best way to make a muscle grow is to use it up to the safe limit, and then to let it rest for a proper period; then use it again, and so on. We should, then, exercise the stomach in the same way. In order to do this I have thought out a plan of feeding, which

I have called the Natural Method of Infant Feeding, which differs considerably from the so-called scientific feeding, which is, or was up to a short time ago, taught in all works on the subject.

Scientific feeding seemed to be based on the idea that the infant's stomach should be always busy digesting food. So the time it took to digest a certain amount of food was carefully calculated, and as soon as that time was up the infant was again fed, no interval for rest being allowed. It was even taught that the infant should be wakened at the set time and fed a certain amount. A baby cannot always digest the same amount of the same kind of food in the same number of minutes, and the result was that the baby's stomach was never properly distended, was never allowed to rest and nearly always contained some of the last feeding, when the next feeding was put into it. This residual, partly digested food, was often in a state of fermentation, with the production of gas that interfered with the process of digestion, and caused the infant much discomfort, besides interfering with its proper growth and development. I used this method for about ten years. It was better than the old, slipshod way that was used before, but was far from perfect. Previous to the introduction of scientific feeding, most mothers would nurse the baby whenever it cried, giving it just enough to quiet it. This was worse yet. In neither of these ways do the lower animals suckle their young. I have watched them, and from their ways of handling their young, have deducted the following rules for the feeding of infants. These rules apply equally to breast-fed and bottle-fed infants:

1. Never feed an infant until you are sure it is hungry. It is illogical and unnatural to feed an infant when it is not hungry.

2. Never feed an infant at exactly regular intervals. It is illogical and unnatural to expect an infant to be hungry and ready for more food at exactly regular intervals.

3. When you feed an infant give it all it will take of a proper and palatable food. Do not let it fall asleep too soon; shake it up and get it to take a little more. If it "runs over" it does no harm. Feed it enough to distend its stomach. It is impossible to over-distend an infant's stomach, except by too frequent feeding.

4. As soon as an infant is fed, and fed full, it should be allowed to sleep. This

sleep should be encouraged to continue as long as possible. A baby will sleep longer in a quiet place than a noisy place; longer in a cool place than in a hot place; longer out of doors than in the house; longer with a moderate amount of covers than with too much covering. An infant should never perspire from too much covering.

5. Do not feed an infant as soon as it wakes. First give it a drink of water. Then change it, adjust its clothing, give it fresh air, coddle it, talk to it, give it more water, do everything you can to keep it quiet and contented as long as possible. Finally let it cry a reasonable length of time. This crying prepares the stomach for its next meal.

6. When the infant has cried sufficiently and nothing else will quiet it, when the stomach is completely empty and has had enough time to contract and rest, then feed it again, and feed it full, as before. In this way the stomach muscles will be properly developed and the infant will become a child with a normal stomach and natural digestive powers.

A majority of adults have stretched stomachs, which are more or less prolapsed. This abnormal condition is started by improper feeding in infancy. The infant's stomach cannot be dilated by giving too much food at one feeding, but the process of chronic dilatation can easily be begun by feeding the infant too frequently. It is the failure of allowing the infant's stomach time to contract and rest that starts the trouble. In using this Natural Method of Feeding it will soon be discovered that we are feeding the very young infant about every two hours up to two weeks of age, *not exactly*, but approximately every two hours. And that the intervals gradually become lengthened until at the age of two months the infant will be having five feedings through the day and one in the middle of the night in most cases. It is now time, i. e., at two months of age, to stop the night feeding, giving for a short time in its place a bottle of warm water.

Now we begin to work very gradually toward regular feeding, which should be fully established by the ninth month, provided the baby has four good teeth. Sometime during the tenth month the feeding should be so arranged that the infant gets three full feedings in each day—morning, noon and night, with two lighter feedings, one in the middle of the forenoon and one in the middle of the afternoon. These five feedings are generally continued until the

infant becomes a child at the end of the twenty-fourth month. This, however, depends largely on the infant. In some robust babies, who will take a large amount of food at each feeding, the number may be reduced to three meals a day during the eleventh month, or at the age of one year. We should always remember that the fewer the feedings, the better, so long as the infant is gaining in weight and strength at the proper rate.

There will always be a few more or less feeble children, who will have to be fed five times in each twenty-four hours, possibly even up to the sixth year, but these few are the exceptions that prove the rule.

Much harm is done by allowing little children to eat between meals. The temptations of ice cream, soda water, candy, fruit and chewing gum are hard to resist, and the parent is often as weak as the child in resisting. We believe it is sometimes a good plan to allow these little children ice cream, or even candy, as a part of many meals, as an inducement to refrain from them between meals. Older children can easily be persuaded from eating between meals if they have been properly handled when they were younger, but a child of eleven or twelve, who has always been allowed to eat at any and all times, is hard to cure. Drastic methods are sometimes necessary. Adults, who are "children of a larger growth," are still harder to cure. They have a will of their own and often a perverted will. It is about as hard to cure a chronic glutton, as it is to cure a chronic alcoholic, and he will give the same reasons for not reforming. When, however, the patient really desires to be helped considerable can be done for him. He should be kept in bed for from three to six weeks, with the foot of the bed elevated at least twelve inches, and put on a carefully selected light diet. When he is allowed to get up again a proper corset should be fitted to him to be worn for at least one month. In the meantime he should be taught what to eat, how much to eat, and how to eat it. He should be taught to chew his food long enough and slowly enough, and never to hurry over a meal. If every mouthful of food is bitten at least twelve times before it is swallowed it takes much less food to satisfy the appetite than if it is swallowed hastily. There is very little danger of too little being taken, and the stomach does not get stretched out of all resemblance to what it should be.

Children between two and fifteen years

of age are often not given enough meat, eggs and milk. They work harder than adults, and use up more muscle than adults in proportion to their weight and height. Besides that they are building, and they should have enough to replace their loss, and something left over to grow on.

Adults, on the other hand, eat far too much meat and eggs. The best rule I can give is this: Cut the amount of meat of the average person in two at forty, again at forty-five and fifty, and cut it out altogether at fifty-five. By "meat" we mean beef, veal, mutton, lamb and pork, and the soups and gravies made from them, also eggs; fats, some fish and a moderate amount of fowls may be eaten, also pure fat pork and pure fat bacon. Milk and oysters can always be taken in any reasonable amount; the other shell fish—lobster, crabs, clams and scallops—are forbidden absolutely after fifty-five.

It should always be a pleasure to eat, but we should never eat simply for pleasure. It is almost impossible to get a crowd together without promising them something to eat and drink, but just say sandwiches, coffee and ice cream and they all come. And they all tell you that it is the social hour after the meeting that they most enjoy. This is a very unhealthy custom. If we are to eat at a banquet, we should go without the next preceding meal at home. But it is not possible to have a pleasant "social hour" without eating?

The drinking of water between meals is a good thing and should be encouraged. Many people drink too little water all of their lives; but no water nor any other drink should be taken while eating. A drink of water should be taken before beginning a meal. Eat slowly, masticate thoroughly and at the end of the meal take your drink. Tea, coffee, cocoa and all alcoholic drinks are all very bad and undoubtedly shorten life. If used at all it should be very sparingly. None of them should ever be given to children under sixteen years of age. As old age comes on, the diet should revert more and more to that of the child. Milk should be the principal standby, with oatmeal and other cereals.

Substitute.—A young man, who had heard that radium was going to cure the world of all its ills, entered a chemist's shop and asked:

"How much is radium an ounce?"

The chemist smiled and named a figure which made the young man blink.

"Really?" observed the customer. "Then give me an ounce of cough lozenges."

OBSERVATIONS ON TWENTY-THREE CASES OF FOREIGN BODIES IN THE ESOPHAGUS AND THE BRONCHUS

By Henry Boylan Orton, M.D., F.A.C.S.,
Newark, N. J.

The ages ranged from ten months to seventy-eight years.

The foreign bodies consisted of an India nut kernel, three pieces of beefsteak, a small twig of cedar, a five-cent piece, a copper rivet, five chicken bones, two nutshells, one coin, two common pins, open safety pin, screw, marble, eggshell, teaspoon and fifteen inches of tubing.

The location of the foreign bodies were as follows: Right bronchus, 2; esophagus, 15; larynx, 2; mesal branch of right stem bronchus, 1; left bronchus, 2, and stomach, 2.

Anesthesia: General was not used in any case. Morphine and atropine were used in three.

The one that presented the most serious problem was the case of a seventeen-month-old child, who had swallowed a copper rivet, which had remained in the esophagus for three weeks. An xray was taken, after the child had the second attack of choking, with bloody expectoration. The child was in bad condition when the case was esophagoscoped, and the difficulty encountered was to deliver the foreign body from its position caused by ulceration and perforation of the esophagus and trachea. The rivet was removed in thirty-five minutes, the child dying twelve hours later of media stinitis. This was originally a foreign body case, and had been treated for bronchitis.

It also brings up the question of four other cases of mistaken diagnosis; one of a nut kernel in the right bronchus of a child five years of age, a marked laryngeal tracheo bronchitis that had already developed and antitoxin given. The cause was the nut kernel in the right bronchus, which was removed in eighteen minutes; it being necessary that same evening to do a quick tracheotomy, after Jackson's method, for drainage of the lung. The tracheotomy was done in fourteen seconds, the child making a quick recovery, and the tracheotomy tube removed in ten days.

Another case of a child two years of age that had inhaled a piece of nutshell, which was primarily a tracheal foreign body. The spasm caused by the movable

foreign body, simulating laryngeal diphtheria. Antitoxin given and the case intubated. All cultures taken for diphtheria were negative. I was called into the case to see why the child could not be extubated. The larynx was negative, but on passing the bronchoscope just below the bifurcation in the trachea, in the left bronchus, was seen a piece of nutshell, which was removed without anesthesia in ten minutes, the child having no further trouble.

The Third Case.—That of a peanut kernel in the right bronchus, mistaken for empyema, in which a child five years of age, while eating peanut brittle, aspirated one-half of a peanut kernel, same lodging in right bronchus. The drowned lung giving all signs of an empyema. The case had been aspirated without result. The xray showing a blocked bronchus, and while waiting to be bronchoscoped, the child had a violent coughing spell, and coughed up the peanut kernel. This case brings out the important point of history taken, and do not lose sight of the fact that foreign bodies can simulate other conditions.

The other case of a boy, age five, who had carried a screw in the left bronchus for four years. This case had been treated for pretty nearly every known chest condition—bronchitis, pneumonia and tuberculosis, and it was not until an xray had been taken that the true nature of the case was revealed. This screw was successfully removed by means of bronchoscope and forceps, in six minutes, without anesthesia—the chest rapidly clearing up, following its removal. It also becomes one of the unusual cases, in that the foreign body had been in the lung unobserved for four years.

Another unusual case of a woman forty-seven years of age, an insane patient, who had pushed a large teaspoon down her esophagus, the bowl resting on the diaphragm, which had remained there for four months; it being removed without any anesthesia, in six minutes.

Another case of fifteen inches of stomach tubing in the stomach, which would have unquestionably passed by rectum, had not the case been operated on, at which time they found that one-half of the tubing had already passed through the pyloric end of the stomach. It seems to be undue haste in operating on a foreign body that would have passed.

Another case, that of a woman, fifty years of age. While eating cake, she felt something stick in her throat. An xray was taken, which showed a common pin

in the esophagus, point down, and pointed in the direction of the trachea, below the crico pharyngeus muscle. An esophagoscopy was done, and the pin removed in twelve seconds. The difficulty encountered was in preventing the point of the pin from perforating the esophagus, as the xray showed the pin very near perforation. Swelling of the tissues around the pyriform sinus had already taken place.

The result was extraction and cure in twenty-one cases. A marble passed by rectum, a very large open safety pin in a child was removed by gastrotomy. The stomach tube was removed by gastrotomy. There was one death, not the result of esophagoscopy, but due to the ulceration and perforation of the sharp copper rivet through the esophagus and trachea, that case dying twelve hours after the removal of the rivet. The time necessary for the removal of all cases ranged from five seconds to thirty-five minutes. The post-operative period was uneventful, with the exception of one case, in which it was necessary to do a tracheotomy.

CONCLUSIONS:

1. Foreign bodies in larynx, trachea and bronchi are being mistaken for diphtheria, empyema and tuberculosis.
2. Think of foreign bodies, and do not try and fit a disease to the signs ascertained, for it may be a trying thing to put a square block into a round opening.
3. Always take the history into consideration. Don't say that no foreign body can be present; look for it.
4. Do not subject the patient to unnecessary abdominal operation until foreign body fails to move for three days.

Papers were received from Dr. Jacob Roemer, of Paterson, on 'The Principles of Deep Xray's Therapy,' and from Dr. M. J. Synnott, of Montclair, on 'Insulin Therapy,' too late to be set up for this issue of the Journal; they will be inserted next month.

County Medical Societies' Reports

BERGEN COUNTY

Frederick S. Hallett, M. D., Reporter.

The Medical Society of the County of Rockland, New York, and the Bergen County Medical Society held a joint meeting at the Lederle Antitoxin Laboratories, Pearl River, N. Y., on May 16, at 2 p. m. The host, Dr. R. O. Clock, provided a very interesting program, consisting of special demonstration—The production of anti-pneumococcic serum and an address by Dr. A. R. Dochez, of the Presbyterian Hospital, N. Y., department of practice of medicine of Columbia University, on "Treatment of Pneumonia."

June Meeting

The Bergen County Society held its regular meeting on June 12 at 8:30 p. m., at the

Union League Club, Hackensack, Dr. Conrad, the president, in the chair; twenty-five members being present.

Dr. Henry Dawson Furniss, of New York city, gave a very interesting and instructive talk on "Urologic Diagnostic Methods in Women," illustrated with lantern slides. A social service followed the scientific program.

BURLINGTON COUNTY

Daniel F. Remer, M. D., Reporter.

The regular meeting of the Burlington County Medical Society was held at Cole's Hotel, Moorestown, on Wednesday, June 23, 1923.

Drs. Rowland S. Phillips, Moorestown; Maximilian A. Shurter, Riverside, and Daniel C. Arnold, Roebbling, were elected members of the society.

Dr. Richard Anderson, of Burlington, had prepared the following program: "Fracture of Skull Diagnosis and Treatment," by Dr. Thomas A. Shallow, Philadelphia; "Indications for Periarterial Sympathectomy," by Dr. George Muller, Philadelphia.

Dr. Charles P. Noble, of Philadelphia, was the guest of the society.

After dinner the society adjourned to meet in Burlington in October. Dr. Alexander Marcy, Jr., Riverton, has been critically ill at his home. Dr. Joseph Kuder, of Mt. Holly, is spending the month of July on an extended trip through Thousand Islands and Canada.

MORRIS COUNTY

Marcus A. Curry, M.D., Reporter

The Morris County Medical Society met on May 29th at the Shongum Sanatorium—the Morris County Tuberculosis Hospital—the occasion being the spring inspection and luncheon which the Board of Managers inaugurated last year and which bids fair to become an annual fixture. The society held its meeting on a commodious porch of the nurses' pavilion, with President Lathrop presiding over a good attendance of members; Dr. Runyon of the Essex County Society also being present.

The routine business was transacted and the recommendations of the Nominating Committee of officers and delegates for next year were presented for action of the society at the September meeting.

The passing of two members of the society was officially recorded in the following memorials:

The members of the Morris County Medical Society have learned with deep sorrow of the death of their late associate, Dr. James Douglas, and desire to give public expression to their sense of loss and their appreciation of his worth.

Dr. Douglas, prior to his graduation from the New York University, in the year 1880, conducted a drug store in Morristown, New Jersey. He was a student of Dr. Frederick Wooster Owen of Morristown and, on graduating in medicine, still conducted his drug store until his practice became so extensive that he was obliged to relinquish it.

In 1886 he began to serve the Town of Morristown as Health Physician and continued to serve in that capacity until his death. The community owes a great debt of gratitude to Dr. Douglas for the skilful manner of combating many contagious epidemics that have swept

the town in the last thirty-five years and earned for himself a recognized name throughout the county and state, as an expert in small-pox and scarlet fever.

For many years he was an active member of the Medical Staff of the Morristown Memorial Hospital, devoting a great deal of his time to the Barker Pavilion for contagious diseases. In 1902 he was elected treasurer of the Morris County Medical Society, which position he held until 1921, and the records show that a more faithful attendant and zealous treasurer could not have been found.

For a long time he has been a permanent delegate from the Morris County Medical Society to the State Medical Society, during which time he has not missed a meeting.

We desire to place on the minutes of this society in this simple way our tribute to Dr. Douglas, and request that our secretary send a copy to the family.

Clifford Mills, G. A. Becker, Marcus A. Curry, Committee.

In the death of Dr. Arthur W. Condict of Dover, New Jersey, the Morris County Medical Society have lost another of its pioneer practitioners.

For more than forty years—many of them under the tutelage of his venerable father, the late Dr. Isaac W. Condict—he practiced medicine in Morris County. His earlier days of practice were under conditions in marked contrast to those of the present day—no motor cars, few telephones, no paved streets and few of the instruments of precision in diagnosis had been developed; and yet, working under these difficulties, he attained by his patience, his kindness and his devotion to duty, a place in the hearts of his patients that is granted few of us today.

The expression of genuine grief by patients whom Dr. Condict had treated for more than forty years, are an eloquent tribute to the respect and esteem in which he was held and identifies him with the type which is slowly disappearing—the real, genuine family doctor.

His conduct as a physician and his life as a Christian gentleman are worthy of emulation; and we feel that in the passing of Dr. Condict this society has lost a valued member, and the community a citizen of the highest type.

W. F. Costello, H. W. Kice, Committee.

At the conclusion of the formal meeting of the society the members mingled with the guests of the sanatorium, among whom were members of the Board of Chosen Freeholders, members of the Anti-Tuberculosis Association and the Visiting Nurses' Association, Co. Lloyd, Superintendent, Morristown Memorial Hospital, members of the New Jersey Citizens Cooperative Committee for Institutional Development, including Miss A. Leslie Hill, General Secretary, and a galaxy of public-spirited citizens, aggregating a group of approximately two hundred. An inspection of the entire establishment was made under the guidance of President Thomas B. Leonard of the Board of Managers, Dr. Frank H. Pickney, attending physician and Miss Kathryn E. Dandley, Superintendent of the sanatorium. The tour covered the wards, solariums, diet kitchen, laundry, storeroom, the latter showing a goodly residue of last season's crop of fruit and vegetables attractively and palatably can-

ned and from which the sanatorium draws its supply during the winter months of home-grown foods of these varieties. The sanatorium, in every respect, was found fully up to the standard of unimpeachability and verified the high opinion in which Superintendent Miss Dandley is held by the managers of the sanatorium and the physicians who visit the institution throughout the year.

The tour of inspection being completed a delicious luncheon was partaken, provided by the management and served by "Day" of Morristown and this pleasant task being performed to the satisfaction of everyone the members of the society and other guests assembled on the spacious porch and occupied every point of vantage of the Nurses' Home to listen to the addresses of the day.

President Mr. Leonard of the Board of Managers, being "To the Manor Born," had no difficulty in putting everybody at ease in a cordial speech of welcome, as follows:

"Members of the Morris County Medical Society, members of the Board of Chosen Freeholders, members of the Anti-Tuberculosis Association, Visiting Nurses' Association, friends and well-wishers of the Shongum Sanatorium—we welcome you here on this beautiful May day. This is the second occasion on which we have had the pleasure of the presence of the Morris County Medical Society and we trust we may have your company at the spring meeting next year. I think you will all agree with me that the sanatorium never looked better than today. I have served on the board of managers since the inception of the sanatorium in 1912, through the influence of our late good friend Dr. Henriquez, and I never saw the institution look so well as today—due to the unflinching efforts of our very competent superintendent, Miss Dandley, than whom I never saw anyone with a greater antipathy to dirt. This is your hospital, you pay for its maintenance and you are interested in its progress and we have the equipment for the doing of much good in the county.

"During the five months of 1923 there were twelve patients admitted upon the recommendation of the Morris County physicians; whereas for the same period of 1922, there were twenty-one patients admitted. The average daily number of patient so far in 1923 has been twenty-five; whereas for the past three years it was thirty. If this were a true reflection of the conditions in the county with regard to the spread of disease it would be gratifying; but, unfortunately, it was not the case. With a county population of 25,000 all of the thirty-five beds should be occupied and with a waiting list. This institution can do its best work with incipient cases and those are the cases we are desirous of getting and with your co-operation we are satisfied that this can be brought about."

President and Master of Ceremonies, Mr. Leonard, at the conclusion of his address of welcome presented, Dr. Lathrope, president of the society, who said:

"I wish in behalf of the Morris County Medical Society to extend our thanks to you and the Board of Managers of the sanatorium for your hospitality. A year ago these 'meetings' began, and I am using the plural word advisedly because Mr. Leonard suggests that we

have more of them; and that shows that we behaved ourselves in the past and I trust this time we have earned another invitation. (Mr. Leonard: You have!) I think it is extremely important to have meetings of this character—important for several reasons. We, as doctors of the county, know little enough about the hospital up here; we send patients but the hospital is a little out of the way and we never come to see them; the four or five miles seems to make a gap that keeps us in ignorance of what is going on and I quite agree with what Mr. Leonard says with regard to this; I think that indicates a little bit of indifference on the part of us medical men to what the hospital is doing and I think we should take it from that viewpoint and keep the place more in mind and come up here oftener than once a year and see what is going on and what is being done for our patients. The same way with the rest of you who are not professional people: This is your hospital—you and all of us are paying taxes to keep this place going; it is not private institution; we are all interested in it and it is one of the great factors in this community for the prevention of the spread of tuberculosis. Now that should be kept very definitely in mind and the more the public and community at large know about how the hospital is run, the better." "Of course the hospital is dressed up today, with a new coat of paint, especially for this meeting, and things are washed down and all that sort of thing; but I have been here when there was no meetings and the cleanliness and good order of today you can see at odd times and all the year around.

"Another reason why we feel that these meetings are a good thing is that we think it is helpful in numerous ways for the medical profession here in the county to get together with the public and to enjoy with them whatever scientific program we can have at least once a year; and I am very glad to receive, and I accept right now, Mr. Leonard's invitation for a similar meeting at this institution next year. Last year our subject was Tuberculosis and the Early Recognition and Curability of Early Cases of Tuberculosis. As many of you remember, we heard Dr. James Miller at that time. This year we have broadened the subject a little bit and shall hear something on the subject of Preventive Medicine. Preventive medicine is not a modern institution by any means; those of you who are familiar with the Old Testament, and I hope some of you are, will recall the Mosaic Laws and the Mosaic laws on health are foundation of our present day Board of Health. There have been some important steps in preventive medicine since the time of Moses. One I might mention is that of the Chinese, who believed in paying the doctor by the year and deducting therefrom all the days of the illness. Janner, in 1796, made the first contribution to preventive medicine in the way of actually combating specific disease, with the development of smallpox vaccination; this was introduced in this country soon afterwards at the beginning of the last century in Boston. Then as you go on Pasteur came along in the last half of the last century with his work in bacteriology; practically all of which was based on the idea of prevention rather than the cure. In the early '90s diphtheria anti-toxin was de-

veloped and in the same decade certain Spanish observers thought they had enough evidence to convict the mosquito of carrying malaria and yellow fever; proof of the malaria taint of the mosquito was soon established and in 1900 or 1901 in Porto Rico American Army Medical Officers laid down their lives in the development of the idea that yellow fever was a mosquito born disease; Lazar died and several soldiers who submitted to the experiment of being bitten by mosquitoes that had been closeted with yellow fever patients died. At the same time typhoid fever became more understood and the cause and growth of typhoid organism; and the result of that is that it is a disgrace for any civilized community to have an epidemic of typhoid fever; the Board of Health is responsible and ought to be, if an epidemic reaches any proportion at all.

"Tuberculosis has advanced well into the status called prevention rather than cure. Our own County Tuberculosis Society is doing a great work. They sent last year thirty children to the preventorium, and that is down at Farmingdale in another part of the state and I understand now their idea is to have a preventorium here at some time or other. Individuals are getting the notion that prevention is worth more than the cure and I do not believe there is a doctor here who does not see, each year, an increasing number of men and women coming to them, not because they have something the matter, but because they want to be looked over and want to be told what are their tendencies and what they are to do to keep well. "Another large factor in the modern development of preventive medicine is Child Welfare, since the institution of sanitation and hygiene; and I believe that any state has just so much strength and so much backing, in proportion as it takes care of its children. Of course there are certain retrogressive factors. We know a great many things about what is being done; we see the advantage of this and that; at the same time, with the wiping out of the yellow fever plague in the South, by the work of those men had done there in Porto Rico, when it came to establishing a memorial to those men who lost their lives, I think it is only five or six years ago, those southern states which previously had been swept and decimated by those terrible epidemics of yellow fever, would not contribute a dollar to a memorial of any kind. We don't let lessons sink in; we are a little too hurried and a little too much in a rush of things to take heed of all these things that are going on and apply them the way they should be applied. In our own county we have just had an instance of meddlesomeness on the part of a person or persons who, I suppose, thought they were doing but didn't have enough inclination to find out. You had clinics established which were taking care of forty or fifty children, thirty-one of whom were well children, not sick children, whose mothers were being told how to take care of them and how to keep them well. Somebody comes along and 'puts a finger in the pie' and swoops away the whole thing; I hope only temporarily. But taking that out of the hands of an organization which was managing it thoroughly and well, is just a commentary on the way in which we look at these things. It takes an enlightened community to assent to and put into

action all the ideas that we should have and put into action with regards to Preventive Medicine."

Fletcher Fritts, Chairman of the Tuberculosis Committee of the Board of Chosen Freeholders delivered a stirring address, exalting the management of the sanatorium and commending the idea of having the County Medical Society hold at least one meeting a year at the institution. Dr. Dean-Abell, a member of the society and President of the County Anti-Tuberculosis Association, read an interesting history of the association and of its activities during the past year and outlined the scope of the work which is to be undertaken the coming year. Dr. Haven Emerson, who was Commissioner of Health in New York City under the administration of the late Mayor Mitchell and at present Professor of Public Health Administration at Columbia University, was introduced by President Leonard and in a most delightful and interesting manner drew a graphic word picture from the remote to the present, of the path and progress of his subject which was "The Dependence of Family Life on Preventive Medicine."

Dr. Emerson depicted the increase in the "Expectation of Life" from the fifteenth century when, with Europe swept by war and pestilence, it was but eighteen years; carrying his audience along to the end the Napoleonic wars, hardly more than a hundred years ago, when thirty-three years was the average duration of life of the people of England, Wales and the Scandanavian countries; that some years ago they had reached in England forty years as the average of life; and coming down the aisle of time to the last Federal census in 1920, when the average duration of life in the United States was fifty-five years, from which the hope may be borrowed that with a constantly increasing intensity of the application of preventive medicine and methods, the Biblical three score and ten may be reached as the average expectation of life in this country. Dr. Emerson said that it is interesting to note that the increase in the average duration of life has grown more rapidly in recent years than in the previous years. We look around the country and we see where the expectation of life is higher and lower. In Kansas the expectation of life is sixty years, the highest in the states of the union; while in the cities, we find the greatest longevity in Washington and the lowest in Pittsburgh. Kansas always has been a "dry" state; it always has been an agricultural community, with no large cities and no slums; the stock of Kansas is the survivors of the civil war, men who had gone through the greatest process of elimination that ever has been applied to mankind. Dr. Emerson said that while there is a question whether or not we are ready for the Eighteenth Amendment it is certain to have more influence for longevity than anything since the time of Pasteur; that the social experiment being made by the United States is the most outstanding fact of this generation and we cannot expect to see more benefits from any other source. In New Zealand, sixty-five years is the expectancy of life; ours in fifty-five. What New Zealand has done, we can do. Dr. Emerson also credited the promotion of longevity to the improved social and economic conditions that people have gained by the increase

in the level of wages; stating that the tremendous increase of money distributed among the workers of the country is the most powerful ally in the prevention of tuberculosis. Dr. Emerson referred to the experience of the Metropolitan Life Insurance Company in the operation of its Life Extension Bureau, by which policyholders are invited to examination at no costs to themselves and are put in the way of being treated for their tendencies, which has resulted in a profit to the company of 200% by way of lengthening out of the premium paying period—a convincing argument for preventive medical methods, the value of which is being rapidly understood by the public and which should be encouraged by the practitioners, who should invite a patient to return say in six months, as is done by the dentists. With cameo clearness Dr. Emerson brought out the aptness of the title of his address, "The Dependence of Family Life on Preventive Medicine," by citing a family consisting of husband and his wife with three children, assuming the ages of the children to be seven or eight, five and three; if those parents are taken out of the earning group by tuberculosis at the age of thirty or thirty-five, the children have to be carried right on up to the time when they become of legal age to engage in self-sustaining employment; thus it is seen that with an increasing average longevity there is an inverse shorter period through which dependents have to be carried and cared for; so that with the gradual increase of the expectancy of life relief has to come from a good many burdens that our predecessors have had to carry.

Dr. Emerson's address was replete with facts and figures marking the milestones along the road of progress of centuries in the development and application of preventive medicine and methods and showed that ever-increasing strides up to the present day, upon which may safely be based the hope, closely akin to a foregone conclusion, that life's expectancy will go on climbing steadily toward Biblical three score and ten during the years in our immediate path. At the close, Dr. Emerson received a demonstration of wholesome appreciation of his able address of so much historic, present and future value.

The September meeting of the society will be held at The New Jersey State Hospital at Morris Plains.

Local Societies' Reports

BARNERT HOSPITAL CLINICAL SOCIETY.

A. Shulman, M. D., Reporter.

The 31st regular meeting of the Barnert Hospital Clinical Society, Paterson, was held on April 17, 1923, twenty members being present. Dr. Payne, of St. Joseph's Hospital, was a guest.

Dr. L. G. Shapiro and Dr. Spickers reported the following case: A baby, 2½ weeks old, which was normally delivered, weighed 7½ pounds, and was breast-fed, began vomiting. The baby was not seen until it was 4 weeks old, and then weighed 7 pounds. Examination revealed gastric peristalsis, but no mass. Some food passed through the pylorus, since a fat residue was found in the stools. A thick

cereal mixture, one ounce every three hours, was given. Atrapin sulphate, in a 1-1000 solution, was given, first by mouth, then by rectum, and then by hypo, up to a dose of 15 minims, according to the method of Dr. Sidney Haas. There was no improvement. At the end of five days there was no bowel movement, and the weight came down to 6 pounds 12 ounces.

Operation was then decided upon. Dr. Spickers performed a Rammstedt operation. He found a hard, dense, apparently fibrous tumor of the pylorus. The operation took seventeen minutes. For ten hours the baby seemed well. It then went into shock and died in a few minutes. Death did not seem to be due to hemorrhage. Dr. Spickers said that Strauss, of Chicago, reports excellent results from this operation.

Dr. T. A. Dingman thought that the surgeons were not given a fair deal in these cases; that they should be referred earlier. He called attention to Downes' excellent results.

In discussing the etiology, Dr. Plant offered the congenital theory—that of a disturbed nerve supply to the muscularis, with resultant hypertrophy during intra-uterine life. Pathologically, he said that the tumor was not fibrous, but muscular, and that the stenosis was not due so much to the tumor per se, as to the folds of mucous membrane at the pylorus.

Dr. L. G. Shapiro did not think that this theory was borne out by the facts, especially since vomiting did not begin till the third or fourth week. Other spasmophilic symptoms, such as holding the breath (as in this case), restlessness, etc., indicate that the stenosis is a result of spasm. The proper time for operation is difficult to determine. Pediatricians say that the child is not in danger till it loses a third or more of its birth weight.

Dr. Spickers reported a case of empyema in a baby of sixteen months. Five weeks before admission the baby had pneumonia. On admission, the chief complaint was the high fever. Pus was found in the pleural space (right). The seventh rib was resected in the mid-axillary line. A tube was inserted and clamped; later, the chest was slowly drained by means of a suction apparatus attached to the tube. The baby was discharged in two weeks, the wound being almost healed. Two weeks later the baby was brought back, again because of high fever. X-ray showed obliteration of the cardio-ploremic angle, and the diagnosis of encapsulated fluid was made. The chest was aspirated, and pus was found. Because of movement of the needle with respiration, it was feared that the lung was punctured and the needle was therefore withdrawn. During the operation no pus could be found. The original wound was then reopened and drained. Two days later the child suddenly died. There was no autopsy.

Dr. Pal reported a case of acute osteomyelitis in a boy of 12, who became ill with chest soreness, cough, slight pain over the left tibia and a temperature of 101 degrees. The next day he was better, but on the third day the leg became swollen from knee to ankle, the temperature went up to 104 degrees, the pulse rate to 120, and the patient became delirious. Tender, red spots were found over the ster-

num, right elbow and hand. Rales were heard over both lungs. Blood count—9,000 leucocytes, with 75 per cent. polynuclears.

Dr. Spickers made an incision over the head of the tibia, removed a portion of the cortex, and evacuated a large amount of pus. Culture showed staphylococci. Death occurred soon after operation. Autopsy showed small abscesses in the kidney, both lungs, the heart muscle and the liver.

Dr. Spickers stated that the red spots that were found indicated metastasis and a fatal prognosis.

Dr. Plank emphasized the low blood count, as indicating the overwhelming power of the infection. Dr. Dingman thought that such cases should be treated as an acute emergency, just as a case of acute appendicitis is so treated.

Dr. Holmes reported the case of an alcoholic male patient, about 50 years old, who had been ill for six weeks, with vomiting, chills, fever, diarrhoea, abdominal pain, epistaxis and dyspnea. He had had abdominal symptoms for two years.

When seen, he had a temperature of 101 degrees, icterus, dyspnoea, oedema of the legs. A murmur, indicating mitral regurgitation, was present. The abdomen was distended. The liver was tender and the spleen enlarged. The urine showed albumin and bile. In spite of active digitalization dyspnoea and ascitis increased and death took place, two days later. The diagnosis was cirrhosis of the liver.

Jersey City Hospital Meeting

The regular meeting of the hospital staff was held in the hospital, April 12, Dr. J. Koppel presiding.

Dr. Nevin announced that in accordance with the plans of the hospital, it had been decided to establish a department of immunology in the laboratory, under Dr. St. George, with a clinic to which all cases requiring such treatment might be referred. The clinic days have been fixed as Friday at 2 p. m.

Dr. J. R. Commorato reported five cases of ascities with individual etiology. The doctor reported each case briefly and pointed out to the staff the methods used in arriving at a diagnosis. Dr. Commorato also presented a case of lobar pneumonia, complicated by paralytic ileus and dilation of the stomach. Discussion was had on these cases, in which Drs. Rector, Street, Bortone and Russell Burton-Opitz joined.

Dr. R. M. Howard presented a case of carcinoma of the maxilla. Dr. Howard had the patient present, and stated that the case had been referred to him by Dr. Faison, during his life-time, and that for a couple of years the man had been under Dr. Faison's and Dr. Howard's observation. Dr. Howard expressed himself as very well pleased with the results of the work inaugurated by Dr. Faison and continued by himself. Drs. Bortone and St. George discussed Dr. Howard's case. Dr. J. Koppel reported some instances of pyelography, calling attention to the fact that he was now preparing a paper dealing with this subject, and announced that his discussion had to do with excerpts from that paper. Dr. Koppel cautioned the staff against the use of

the pyelograph in cases where it is not absolutely necessary to use it.

The paper of the evening was delivered in the form of a lecture, entitled the "Principles of Electrocardiography and Their Clinical Application," by Russell Burton-Opitz, M. D., Ph. D., associate professor of physiology, Columbia University, and consulting cardiologist to the Lenox Hill and French Hospitals New York city.

The hospital report for the month of March showed that 776 patients had been admitted during the month, with 413 remaining from previous month; 792 were discharged during the month, 224 cured, 431 improved, 4 unimproved, 76 died and 56 transferred to other institutions. In the dispensary, 2,400 cases were treated, 959 of which were new cases. There were 129 major operations, 113 minor operations.

Jersey City Practitioners' Club.—This club held its Silver Jubilee meeting recently. It was organized in 1898 with twenty members, but was increased to twenty-five and limited to that number. Dr. H. J. Bogardus is president; Dr. W. W. Maver, secretary; Drs. Chambers, Spence and Sexsmith, executive committee. At the Silver Jubilee Dr. J. B. Deaver of Philadelphia delivered an exceedingly interesting and instructive address.

Physicians and Surgeons' Club, Jersey City.

A regular meeting was held at the Carteret Club, March 20, Dr. J. G. Enright acting as host and essayist. The essay was on "Functional Tests in Diseases of the Kidneys." Dr. Mulvaney was elected an honorary member, he having been one of the charter members. The club voted in favor of holding an annual outing, time and place to be decided by committee—Drs. Woelfle, Miner and Hamill.

West Hudson Practitioners' Club.—The regular meeting was held at the Elks' home on March 27. Dr. J. Thompson Stevens, Montclair, gave an interesting talk on "The Treatment of Malignant Diseases, with the New High-Voltage Rays," illustrated with lantern slides. Lyndhurst, Arlington, Kearny, East Newark and Harrison are to hold a drive for a \$200,000 hospital for these towns, as the present institution is often overcrowded.

Medical Section Rutgers' Club, New Brunswick.—The doctors of the medical section of the Rutgers' College Alumni Club held their annual shore dinner on the evening of June 27 at the Allaire Inn. After dinner, Chairman C. F. Merrill called on Dr. D. C. English for a speech, and he responded by giving an interesting account of the State Medical Society's recent meeting at Atlantic City. Dr. English was followed by Dr. Charles J. Sullivan, who referred to the State Society's Golf Club and its meeting and games at Atlantic City.

High Blood Pressure.—The June issue of American Medicine was devoted to the problem of High Blood Pressure and contained valuable papers by several of the ablest practitioners of England, Scotland, Canada and the United States.

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Any member failing to receive the paper will confer a favor by notifying the Publication Committee of the fact.

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All papers, news items, reports for publication and any matters of medical or scientific interest, are sent direct to THE EDITOR, New Brunswick.

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The names of the Trustees, Councilors and Committees will be given next month.

We congratulate our members on the election of these officers, especially of our new president, Dr. Eagleton; Third Vice-President and Secretaries. The committees which did such excellent work last year are continued, with little change in their membership. The Editor and members of the Publication Committee are formulating plans for a larger and better Journal.

All of which means that the year 1923-4 will be a year of increased activity and prosperity.

JOHN B. MORRISON

The Society was fortunate in securing Dr. Morrison's acceptance of the recording secretaryship. His address is 97 Halsey street, Newark.

Dr. Charles D. Bennett, chairman of the Publication Committee, is spending the month of July at Gray's Inn, Jackson, N. H. Letters on urgent business should be sent to him there until July 30. He expects to return home on August 1.

The Editor expects to take his vacation from August 3-25 and from August 31 to September 5, in Maine. His address will be New Brunswick until August 3, from August 25-31 and after September 5.

OUR ANNUAL MEETING

Our readers will recall the Editor's repeated predictions that the 157th annual meeting would be the largest and one of the best ever held. It was held in Atlantic City, June 21-23, and our expectations were more than realized, both in attendance, literary excellence and social accompaniments. Haddon Hall was an ideal place for our meeting and its manager did much for our enjoyment and comfort, as did our Committee of Arrangements, the Atlantic City physicians and especially Dr. Carrington, our efficient Corresponding Secretary. The decision to return to Atlantic City for our annual meeting next year, we believe, was a wise one. We append a letter received from Dr. Hunter, the President, but his modesty leads him to omit statement of the fact that much of the success of the meeting was due to him, and he made one of the best presiding officers we ever had.

The following is Dr. Hunter's letter:

"Atlantic City, Haddon Hall, the dates set and the untiring zeal and fidelity of the Committee on Program and Arrangements, the Committee on Scientific Work, the Committee on Credentials and our Corresponding Secretary, Dr. William J. Carrington, are the factors that stand out for the success attending our recent annual meeting. The names of Reddan, Olmstead, Carrington and Schauffer are those to conjure with when it comes to pulling off a convention of medical men in New Jersey. No set of men could have worked more faithfully and successfully for our comfort and entertainment. The infinite amount of detail involved can only be appreciated by those in whose hands lay the fate of the recent annual meeting.

"The work of the sessions demonstrated that the committees of this Society are alive and realize their responsibilities. The character of the papers read speak for themselves and their authors. They were eminently practical and made up in a large measure by men from our own ranks. The 'Oration in Medicine,' by Dr. Berthold S. Pollak, was a classic, inspirational in the highest degree; teeming with the lofty thoughts and ideals that have been the inspiration of our splendid profession in times past and present, a re-incarnation of all that is noble in the practice of medicine, ancient and modern.

"The 'Fellows' also, with thought and suggestion, helped in no small way to guide your President through the long hours of the various sessions. In fact if I were to sum up the causes for our very pleasant meeting in two words, I would say: "All around 'team work,' everybody helped." Then, too, we are under obligations to the Editor of the Journal for his scheme of continuous publicity for everything concerning the coming meeting, he kept it ever before us, and thus kept alive our interest, making for increased attendance.

The decision of the Society, through its Nominating Committee, to return again next year to Atlantic City and Haddon Hall is a high tribute to the work of the Committee on Program and Arrangements.

"J. HUNTER, JR."

The reports of committees showed excellent work and results. The Trustees meetings were largely attended and contributed much in expediting business and in formulating plans for the future welfare of the Society. The Treasurer's report showed such a splendid balance on hand that the dues were reduced from eight to five dollars for the year 1924, which should help to increase our membership next year to 2,500. That can easily be done if the officers of county societies show the devotion to the profession's welfare that our State Society's officers do.

The following is the report we have received from Dr. Carrington of the attendance:

"Out of seven officers of the State Society, six attended; of the trustees, twenty out of twenty-eight were present; three out of five councilors were present. There were 117 permanent delegates registered; 44 annual delegates, 142 associate delegates, 279 guests, 31 doctors from outside of the State, representing as follows: Pennsylvania, 13; New York, 9; Ohio, 3; Delaware, District of Columbia, Maryland,

Texas, California, Canada and France, 1. There were eighty-six exhibitors. This last item does not mean that there were eighty-six different exhibits, but that eighty-six people, connected with the exhibit, were not registered as guests."

WILLIAM J. CHANDLER

There has been no officer of our State Society who has rendered more service, with greater faithfulness and efficiency, than Dr. Chandler, as our Recording Secretary, and the Editor has the proud satisfaction of having, when President, appointed him to fill the vacancy occasioned by the appointment of Recording Secretary Pierson as Vice-President, in 1897. Since then, Dr. Chandler has been yearly elected, except during his three years' service as Vice-President and President.

It was, therefore, with great reluctance our Society this year accepted his resignation. As a slight recognition of his worth and services, the Society very appropriately elected him an Honorary Member and voted him an annuity of \$500. The Editor takes the liberty of giving the major part of a letter received from Dr. Chandler, as follows:

Dear Dr. English: Your note came as a very great surprise to me. I had not heard of the annuity that the Trustees voted that I should receive, and it will be a greatly appreciated help to me, in view of the heavy losses I have met with.

In answer to your questions I will say: I have attended every meeting of the Medical Society of New Jersey since 1868. In 1897 you, as President, appointed me Recording Secretary to fill the vacancy occasioned by Dr. Pierson's appointment as Third Vice-President, and I held that office until elected Third Vice-President in 1912. In 1916, on the death of Secretary Gray I was again elected Recording Secretary, and have served until our annual meeting this year.

I resigned this office because I needed more rest, and especially relief from the winter's cold, and knew I could get that in Florida, but I would be obliged to be away and could not give the time required to leave one's old surroundings and go to fields unknown at my time of life. It was a matter of deepest regret that I felt compelled to give up the position which I had held so long and loved so well. . . . I shall greatly miss our many pleasant meetings and conversations about the dear old Society, but my interest will always continue to go with it. I have had several interviews with Dr. Morrison, our new secretary, and I am sure he will "make good"—a more efficient secretary than I ever was, but he can never love the Society more than I do. I shall hope to meet with the Society at some of its future meetings.

Hastily and sincerely yours,

WILLIAM J. CHANDLER.

The Transactions of the 157th Annual Meeting will be published in the October Journal.

DRS. BIGGS AND FURBUSH

We lament the deaths of these two eminent sanitarians, both of which occurred during the last week in June, the former in New York, the latter in Philadelphia. Their departure is not only a great loss to the cities and States they served so efficiently, but to the country and the world, in the advancement of sanitary science and practical methods for public health improvement. The New York Tribune, in an editorial, said of Dr. Biggs:

"New York, and with it all the world, is the loser in the death of a man who was internationally recognized as one of the most efficient sanitarians of his time. Dr. Hermann M. Biggs was so modest and unassuming and so averse to self-exploitation that to the public he was personally little known. Yet there were few men to whom the entire public was more directly and deeply indebted for the suppression of disease, the promotion of health and the prolongation of life."

Dr. Furbush's record of work done in this and other countries is worthy of as strong commendation.

PROFITEERING IN MEDICINE

"The laborer is worthy of his hire." "All the traffic will bear." These and similar expressions are in the air today. The dominant thought in the mind of everyone who has anything to sell, is to get the highest possible price for it. This is human (very human) nature. But what has this to do with the medical profession of Nebraska?

The ambition of a large per cent. of the doctors, and specially of the younger men in the profession, is to get into a city, and take up a specialty. Regular hours, absence of nerve-straining anxieties over critical cases, and last, but not least, more of the coin of the realm. The human body is being parcelled out to a wonderful degree. The argument is, that owing to the wonderful results of research work, and advances in knowledge in recent years, it is impossible for one mind to grasp it all. This argument looks reasonable, but there is another side to the picture. The great mass of the common people who suffer have not the price to pay, and they do not like the idea of submerging their manhood, and becoming charity patients. The result is despair, discontent, anarchy. We speak of the cursed system of "caste" in the Old

World—Are we not drifting to a material caste system? Would it be accounted treason to express a belief that if a change is not soon manifest it will not be ten years before some legislature will enact laws establishing maximum fees for our work?

And what is the remedy—not all the traffic will bear, but think of the other fellow, and not force him to feel that he is a dependent. Cut some of those big fees in two. They are dangerous for the future of medicine. While some of us are overcharging, the people are getting discontented. Don't grumble over the profiteering on sugar. The war is over. Get back to a reasonable basis, or we will face what most of us dread—State Medicine. Have a clear conscience, and live longer. If this be treason, make the most of it.—M. L. H., in Nebraska State Jour.

THE FAMILY DOCTOR

From the New York Tribune.

It is pleasant to hear a physician with a specialty praise the old-fashioned family doctor, the "general practitioner" who has largely given way in the city to the specialist, but in the country is, as ever, the present help in time of trouble. For him there are gratitude and affection that need no analysis. He deserves all the good things Dr. Frankwood E. Williams said of him at the State medical convention.

He may be old-fashioned, but he is as able a psychologist as the most modern, in the view of Dr. Williams, medical director of the National Committee for Mental Hygiene. The best remedy in his medicine chest is common sense, which, tactfully applied, is a famous way of mental healing. His best dose is optimism. That is what all four patients out of five need, if Dr. Williams is right in his diagnosis. Only the fifth patient needs the specialist, and the family doctor in general may be relied upon to take such cases to consultation.

There is no danger of disparaging the skill and knowledge of the physicians and surgeons who are masters in specific fields; but it is good to be reassured that the family doctor, until lately the backbone of the profession, is by no means obsolete.

THE LIMITATIONS OF MEDICAL SCIENCE.

Scientific medicine loses nothing when its followers admit, as they often do, that their present knowledge of the human body and its processes still falls far short of what they wish. It has been suggested that if

the physician admits that the number of drugs that are really specific in the treatment of disease is limited and that, in the majority of cases, nature accomplishes the cure—with some help from the physician—the public will lose confidence in scientific medicine. We do not believe it. The intelligent part of the public is perfectly cognizant of the limitations of experts in all lines. There is nothing sacred about modern medicine or about any other branch of modern science, except the sacredness of truth. There is nothing mysterious about it, although the subject is infinitely complex and there is a tremendous amount yet to learn. Mystery and secrecy can be left to the quack and the "patent medicine" vender. The honest physician admits the limitations of his science and his art. Yet, when all the admissions possible have been made, modern scientific medicine offers more to the human race in the prevention and cure of disease than do all the cults, 'pathies, 'isms and fads in existence. And deep down in its heart the public knows it.—A. J. C., in Hygeia.

THE KNOCKER

The knocker is a curious cuss;
He never starts to whine
Or fling his envious shafts at us
Until our work is fine.
It's only men with skill to do
Real work he tries to block;
And, so, congratulations to
The man the knockers knock.
—William Angus, in Medical World.

Miscellaneous Items

The Jefferson Medical College, Philadelphia, has elected Dr. Bowman C. Crowell of Charleston, South Carolina, Professor of Pathology in that institution to succeed Dr. W. M. L. Coplin, who resigned a year ago. Dr. Crowell is a native of Nova Scotia; graduated from McGill University, Montreal, and has had extensive experience in Pathology in that country, in the Philippines, in Brazil and lately in the Medical College of the State of South Carolina.

Relaxation of Prohibition Regulations

Regulations affecting liquor supplies of hospitals and retail druggists have recently been changed, according to an announcement by Federal Prohibition Commissioner Haynes.

State directors are given new orders to expedite applications of hospitals and druggists to the full limit of their yearly and quarterly allowances. If they do not use their entire quota in one quarter they may draw the difference in a later period. This regulation is designed to increase supplies in winter seasons, when they are regarded as more necessary in cases of sickness.

"As the needs of hospitals are imperative, their applications should be subjected to as little delay as possible and should have priority of consideration," the new orders declared.

Wireless Surgery

It is gratifying to be able to record, says an editorial writer in *American Medicine* (New York), that the world's first honors of performing a wireless surgical operation and curing illness by wireless prescription go to an American physician, Dr. W. S. Irwin, ship's surgeon on the liner President Adams. He tells the story in the following paragraph:

Dr. Irwin's feat of wireless surgery, which passed almost unnoticed at the time, occurred nearly ten years ago, long before broadcasting became a household word. At that time, while sailing in the Caribbean, Dr. Irwin's ship picked up a wireless message reporting that a seaman on a distant vessel was in a critical condition, his leg having been caught in some machinery, and asking for advice.

Dr. Irwin immediately responded with a minute message advising the amputation of the crushed member, and directing the operation in a series of detailed instructions. The operation proved a great success. During a recent eastward trip of the President Adams a wireless message was picked up by that liner reporting a sailor on another ship far out at sea to be on the point of death from pneumonia. Dr. Irwin immediately got in touch with the captain of the vessel, which proved to be the freighter Hickman, and got a satisfactory diagnosis. He then wirelessly a prescription. The captain of the Hickman replied that he did not possess on board the medicaments prescribed.

The task then became complicated and prolonged. Dr. Irwin requested a report of the complete list of drugs to be found on the freighter. The reply soon came, and the surgeon found that the supply was extremely limited. However, he made the most of the situation, as it was impossible to dispatch the necessary medicaments, and for the next three days messages were exchanged almost hourly between the two steamers. On the third day, Dr. Irwin's efforts were rewarded with a cheerful message stating that the seaman was responding to the treatment and was gradually regaining his strength. The modern bard in quest of epic material could not find a more alluring theme than this battle against death by wireless. The achievement is a notable one, and it opens up a vista of enormous possibilities.

Syphilitic Interstitial Pneumonia.—The reasons for thinking this interstitial pneumonia syphilitic are: (1) the presence of typical syphilitic stenosis of the rectum and probable syphilis of the liver in the same body; (2) the situation of the interstitial pneumonia in the lower lobe, the presence of multiple; (3) the enormous growth of vascular interstitial connective tissue containing many round cells in foci and perivascular concentrations.—R. Floyd, New York Path. Soc.

The report of the Middlesex County Tuberculosis League annual meeting and President Silk's address will be given next month.

Hospitals; Sanatorium.

Hospital and Home for Crippled Children, Newark, graduated, recently, seven nurses from its training school. Dr. John E. Tope delivered the address, and Dr. S. A. Twinch awarded the diplomas.

Homeopathic Hospital Training School

Twelve nurses graduated from this school last month. Dr. Arthur H. Thompson, East Orange addressed the meeting.

Hospital Training Schools' Graduates.

The following schools graduated nurses during the month of June: Bayonne Hospital, 9; Memorial Hospital, Morristown, 10; Muhlenburg Hospital, Plainfield, 9, and St. Peter's Hospital, New Brunswick, 7.

Bonnie Burn Sanatorium.—Dr. J. E. Runells reports for the month of April that on April 30 there were 258 patients in the sanatorium, 145 males and 113 females. This includes eighty children in the preventorium. Since the last report, forty-three patients have been admitted, twenty-three males and twenty females. Thirteen of these admissions went to the preventorium. Among these admissions were four re-admissions.

The admissions are classified as follows: Pretubercular, 15; moderately advanced, 4; far advanced, 24. Present, May 31, 245. This number includes seventy-eight children in the preventorium.

Hospital Is a Laboratory.—The value of the hospital as a laboratory cannot be too greatly emphasized. The congregation and variety of cases makes possible in a few months an experience that it would take otherwise years to obtain, but in this bedside experience should be included those diseases now prevalent, such as mental, tuberculosis, and pediatrics. Furthermore, definite and comprehensive experience should be given in normal child life. The period of case experience should be of sufficient length and continuity to fix impressions and enable experimentation for the end result.—A. W. Goodrich, Hospital Social Service.

The Hospital and the Family.—Of the greatest importance in this scheme of education will be the acceptance by the hospital of the family as its unit of responsibility. The fact that the hospital wards represent but one piece of the machinery in any health program, that the dispensary, the health station and all their scientific equipment, with their varied and adequate personnel, even the home, the occupation, and the recreation of the individual case are part of this project, will insure that case technic not less than case experience shall be included, throughout the professional preparation of the nurse. There must be such provision of paid staff for the care of the patient as will enable each student to secure a complete cycle of experience and a reasonably close correlation of theory and practice as expressed in nursing procedure, problems of nutrition, etc.—A. W. Goodrich, Hospital Social Service.

Deaths.

BROUGHTON.—At Bloomfield, N. J., June 18, 1923, Dr. William R. Broughton, of that city. Dr. Broughton was born in New York, November 3, 1866; he graduated from the Bloomfield High School, Williams College, and in 1890 from the College of Physicians and Surgeons, New York city. He began practice then in Bloomfield. He became known nationally through being the oculist for foreign mission boards. He was a member of the State Commission for the Blind, an elder of the First Presbyterian Church, Bloomfield; superintendent of Broughton Memorial Chapel, trustee of the Job Haines Home for Aged People and a director of the Bloomfield Trust Company. He was a member of the Essex County Medical Society, the Medical Society of New Jersey and of the American Medical Association.

ENDICOTT.—In Plainfield, N. J., May 31, 1923, Dr. George W. Endicott, aged 70 years.

At a special meeting of the Union County Medical Society, the following resolution was adopted and ordered sent to the Journal:

"The Union County Medical Society learns with regret of the death of Dr. George W. Endicott. He was a member of this society for forty-five years. He was a successful practitioner of his art and was highly esteemed by his patients. His ability in surgery was recognized many years ago. He was a man of pleasing and distinguished appearance, and his loss will be felt by his many patients and friends.

"Norton L. Wilson, J. B. Harrison and Robert J. Montfort, Committee."

Public Health Items.

Typhoid Fever Epidemic at Rockaway.

There has been, during May and June, forty cases of typhoid fever, with three deaths. It is believed to have been caused by contaminated water supply.

New Jersey Health Report:—There were 3,887 deaths in the State in April; 491 of children under one year of age, 206 between one and five years and 1,510 of persons sixty years or more of age. The death rate was 13.59.

New Jersey Health Report.—New Jersey's birth rate for 1922 was 22.5, while it was 24.1 in 1921, and the death rate was 12.2 last year, and 11.7 in 1921. During the months of October, November and December, 1922, the births in New Jersey totalled 17,715, the same months in 1921 totaled 19,042. The number of deaths for the same period were 10,148, in 1922, and 9,294, in 1921.

National Birth and Death Rates.—The birth rate for twenty-four States in 1922 was 22.7, as compared with 24.4 in 1921. The mortality rate in thirty-three States for 1922 was 11.9, as compared with 11.6 for the year

previous. The State which had the highest birth rate last year was North Carolina, with 30.2, while Washington had the lowest, 18. In the year previous—1921—North Carolina also was first, with a rate of 33.8, and Oregon last, with 19.3. Not one State of the twenty-four last year showed an increased birth rate over the year previous, showing that the decrease in births was not confined to certain States or sections, but was general throughout the country. The State with the lowest mortality rate last year was Idaho, with a figure of 8.1, while Maine, with a rate of 14.7, had the highest. In 1921, Montana had the lowest mortality rate, 8.2, and Vermont had the highest, 14.2. Of thirty-three States for which figures are available for both 1921 and 1922, five showed a decrease in their mortality rates and three remained the same. These States showed mortality rate decreases, as follows: Michigan, from 11.6 to 11.4; Mississippi, from 11.1 to 10.6; Pennsylvania, from 12.4 to 12.3; Virginia, from 12.2 to 12.1, and Wisconsin, from 10.5 to 10.1. Indiana, Maryland and Ohio remained the same.

Campaign in England Against Cancer.—A number of the foremost British physicians, surgeons and other prominent persons have formed an organization for the promotion of cancer research. The first step in an energetic movement to encourage the investigation of the disease was the issue of an earnest appeal throughout the British Empire for the funds to aid in the work. The movement is to be known as "The British Empire Cancer Campaign." According to official statistics for the year 1921 cancer was answerable for one in every seven deaths of persons over thirty years of age in England and Wales.

Measles:—Measles is most contagious before the rash appears; (2) The germ is in the nose and mouth discharge; (3) The disease is most dangerous in little children; (4) To avoid complication, get to bed when you first suspect that you have measles and stay there until the fever is gone; and (5) Every case must be reported immediately to the health officer.—Health Talks, Dr. H. M. Biggs.

Rockafellow Foundation Work for World Wealth.

Activities of the Rockafellow Foundation during the past year are summarized in a report issued by Dr. George E. Vincent, president of the Foundation. During the year the Foundation has endowed chairs for medicine and surgery in Hong Kong University; pledged \$1,125,000 for new buildings for the college of Medicine at the State University of Iowa; financed the Peking Union Medical College. Agreed to appropriate \$300,000 for laboratories and premedical teaching in two Chinese institutions and missionary university at Peking; aided nineteen hospitals in China to increase their efficiency; promised to aid medical schools at Sao Paulo, Brazil, and Bangkok, Siam. Pledged \$2,000,000 for a school of hygiene in London; shared in malaria control in thirty-four country-wide and thirty-two town demonstrations in ten Southern states and continued field studies and surveys in the United States, Porto Rico, Nicaragua, Brazil, Pal-

estine, Australia and the Philippines. Cooperated with Mexico and other governments in restricting the prevalence of yellow fever; resurveyed centers of hookworm infection in four Southern states; took part in promoting full-time health service in 163 counties in eighteen states of the United States and in several counties in Brazil and financed many other health movements.

Exhaustion as Factor in Etiology of Tuberculosis.—Dancing at the end of a day's work and indulged in until late hours may have serious effects upon general health. Even outdoor sports, which are certainly to be encouraged, may defeat their chief end if indulged in immoderately or to the exclusion of proper resting period. Child labor, either in factory or at home, excessively long working hours, occupations which cannot be interrupted for Sunday rest, or which tempt, or drive, to excessive effort or "speeding up," all tend to weaken resistance and predispose to tuberculosis. Night schools, overtime, excessive amusements, over-indulgence, and asceticism are all important predisposing causes.—F. C. Smith, Public Health Rep.

The Maternity Center's Service

From the N. Y. Tribune, June 27th.

It is seldom that an institution makes an equal appeal to heart and to head, to the sentimental and to the economic points of men, as does the Maternity Center Association of this city. Saving the lives of babies and their mothers in families ignorant of proper care and precautions and too poor to secure physician's advice when most needed, is a labor of friendship and neighborliness that needs but to be stated to win sympathy and support. But the economic value to a community of such a work is not less important. The better health of the future citizens thus brought into the world and of their mothers saved from invalidism has a continuing value in dollars and cents. The annual dividend to the community in work performed and costs of illness saved is a large item even in the limited area now served by the Maternity Association.

The horizon toward which the Center looks is as wide as the nation. One of its first aims is to train public health nurses who can carry maternity care far and wide. Nurses from every part of the world have come to the association for training, for observation and for instruction. The task calls for the highest type of ability, combining wide technical skill with a vigorous and sympathetic personality. In an exact sense the nurses of the Center are missionaries carrying the spirit of maternity service, before and after birth of the child, wherever they may be called.

Now that the national funds of the Sheppard-Towner act have been made available for the State Health Department the demand for the Center's training and its nurses will be greatly increased. There is more need than ever for pushing its work both for the mother of New York City and of the State. The Tribune feels sure that its readers will be glad to have this work called to their attention. The cost of one clinic for one week is \$13, of one nurse for one week \$33.75. Subscriptions in any amount will be gladly received.

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INSULIN THERAPY*

Martin J. Synnott, A.M., M.D., F.A.C.P.,
Montclair, N. J.

"Insulin" is the name given by Dr. Frederick G. Banting, of Toronton, to his pancreatic extract, containing the active principle of the Islands of Langerhans, the deficiency of which in an individual causes diabetes. At the start, this extract was produced in very small quantity and at great expense, so that only a few well-known diabetic specialists were allowed to use it. The early product was imperfectly standardized, different lots varied in strength, there was danger of hypoglycemia from improper use, and the extract contained proteid substances, which, when subcutaneously injected, sometimes caused tissue irritation and even abscesses, so that Dr. Banting and his associates were very wise in limiting its use to friendly and thoroughly competent hands.

The process of manufacture was patented by Dr. Banting and the patent rights handed over to the University of Toronto, the distribution being under the control of a special committee, known as the "Insulin Committee." The firm of Eli Lilly & Co., of Indianapolis, has been licensed to produce it, under the name "Tletin," and the number of physicians permitted to use it has been gradually enlarged by the Insulin Committee, as the production has increased. Some plan of more general distribution is under consideration at the present time, and probably by August 1, any physician who can demonstrate to the Toronto University Insulin Committee that he has the knowledge necessary to use Insulin safely, will be allowed to purchase from the Lilly company as much as he requires. .

Insulin is standardized by units, and is put out in two strengths, ten units to the cc. and twenty units to the cc. A unit is the amount of Insulin required to reduce the blood sugar in a one kilogram rabbit, which has been starved eighteen hours, from .123 to .045 per cent. It has been found that one unit of Insulin metabolizes 2.5 grams of glucose in the blood of a human being. The dosage is, therefore, determined by dividing the total output in grams of glucose in a diabetic patient during twenty-four hours by 2.5. Thus, if the twenty-four-hour specimen of urine contains 12.5 gm. of glucose, the total daily dose of Insulin would be five units, given in two or three divided doses by hypodermic injection twenty minutes before meals. The average patient, on a carefully worked-out diet, will require from ten to fifteen units daily, in two doses before breakfast and supper, although severe cases often require as much as eighty or more units in twenty-four hours in four or more doses. The price of Insulin has been reduced from twenty-five cents per unit to five cents per unit at the present time, and a further reduction in price is promised for the near future. Thus, the cost to the individual patient will vary from fifty cents to four dollars or more per day. It is sent direct to the physician, permitted to use it, but is billed to the druggist designated by him.

The routine procedure in the management of a diabetic patient is not a simple procedure. Every patient must receive a careful physical examination for evidences of pulmonary involvement, of hyperthyroidism and of focal infection in teeth, sinuses, tonsils and biliary tract. There is reason to believe that the etiology of a certain percentage of diabetic cases is due to an ascending duct infection from an infected duodenum or stomach, oftentimes associated with a biliary infection. The technique of duodeno-biliary, non-surgical

*Read at a meeting of the Orange Mountain Medical Society, Orange, N. J., June 15, 1923.

drainage, originated by Dr. B. B. Vincent Lyon, of Philadelphia, enables us to determine easily and surely whether or not this condition exists, and there is reason to believe that the Lyon treatment, where indicated, is a valuable adjuvant to Insulin therapy and diet.

Blood chemistry at weekly intervals or oftener, to determine the percentage of plasma sugar and carbon dioxide, and daily urinary tests for sugar and acetone are, of course, a matter of routine procedure.

The basal metabolism caloric requirement of each diabetic patient is determined either by a respiration apparatus, which also enables us to say whether or not there is a condition of complicating hyperthyroidism, or by the DuBois surface area formula, which is estimated from the patient's height in decimeters and the weight in kilograms, and is approximately accurate. (See Lusk's "Science of Nutrition," W. B. Saunders, Third edition, page 126.)

The patient is put on a test diet (Wood-yat or Joslin), the calories and carbohydrate percentage of which are reduced daily until the urine is sugar free. When the urine is sugar free, increases are made daily or every two or three days in the calories and the carbohydrate allowance until sugar reappears in the urine. The number of grams of carbohydrate which the patient can metabolize before sugar reappears in the urine denotes the carbohydrate tolerance.

If the patient, on a carefully computed diet, is able to tolerate 600 or 700 calories in excess of the basal metabolism requirement, no Insulin is needed. Mild cases of diabetes like this can be controlled satisfactorily by diet. The more severe cases of diabetes are given Insulin, the dosage being determined in the manner already indicated.

After several days or weeks of Insulin treatment, if the urine becomes sugar free, or nearly so, and the blood sugar level is at a lower level, somewhere near normal, either the Insulin is decreased, if the patient is on a generous diet, or the diet is increased until the patient is getting thirty-five calories per kilo of body weight.

The results of Insulin treatment are certainly most remarkable and gratifying. The patient begins to gain in weight almost at once. The distressing symptoms of diabetes are immediately relieved, the hunger, thirst and weakness being replaced by a satisfied appetite, the sunken cheeks fill out, and the characteristic diabetic facial

expression of depression gives way to a happy, optimistic smile; there is an immediate gain in the patient's strength and working power.

Reactions following Insulin, which are due to a sudden lowering of the blood sugar to a point below the normal, in other words, to a hypoglycemia, are to be avoided by giving the Insulin before a meal, by keeping a trace of sugar in the urine or by our blood chemistry control tests. The reaction symptoms are sweating, flushing, extreme nervousness, tremors, hunger, weakness, followed in severe cases by unconsciousness, delirium, convulsions and even death. The treatment is sugar in some form; by mouth, if the patient can swallow, orange juice, candy, etc., and glucose by stomach tube or intravenously, if the patient is unconscious. A hypodermic injection of epinephrin is always advised if the reaction is at all severe, and if given promptly will, as a rule, be sufficient by itself to relieve the condition, because adrenalin very quickly mobilizes the glycogen in the liver. Prompt treatment, as indicated above, gives almost immediate relief, even in severe reactions. Hypoglycemia is more readily produced in the blood of a diabetic than in a normal individual, because the livers of diabetics do not store glycogen, and Insulin abstracts glucose from the blood of the diabetic faster than the liver can supply glycogen.

The action of Insulin is not a chemical one, because if mixed with blood in a test tube no change takes place. Its action is probably due to the production of a vacuum for sugar in the tissue cells, which vacuum abstracts sugar from the blood.

We have reason to believe that a diabetic patient's tolerance for carbohydrates is increased as a result of Insulin therapy, and that the pancreas regains a portion, at least, of its lost function.

Finally, it is hardly necessary to state that in Insulin we have the greatest advance in therapy since the discovery of the Roentgen ray and diphtheria antitoxin.

TREATMENT OF PARESIS

Certain German investigators, having observed that patients with paresis tended to improve when they became ill with malaria, have been treating paresis by injecting malaria into the blood. The method is still under investigation in this country, as well as in Europe, and its effects cannot be stated with certainty, but there is some prospect that they may prove of value.—Hygeia.

THE PRINCIPALS OF DEEP X-RAY THERAPY*

By **Jacob Roemer, M.D.,**

Paterson, N. J.

With the advent of the high-power transformers able to deliver at the terminals of an xray tube voltages up to 300,000, great progress was achieved for deep Roentgen ray therapy. These machines consist of two transformers of 150,000 volts each, set up in series, and by adding more transformers the voltage can be raised indefinitely. For the tubes in existence, it would be of no advantage to set up transformers of higher power than 300,000 volts. The present deep therapy Coolidge tube can be operated on 250,000 volts, but for continuous, long exposures, lasting for several hours, it is not advisable to go above 230,000 volts.

It is of great importance to apply, at the terminals of an xray tube, as high a voltage as possible, for the higher the voltage the shorter are the wave-lengths of the resulting xrays, and the shorter the wave-lengths of the xrays the greater their power of penetration.

A deep therapy machine and tubes must be standardized very carefully at frequent intervals. The voltage must be carefully calibrated by means of a spark gap, sphere gap and kilovolt meter. These measuring instruments should be checked up by a spectrogram, made with and without filtration of the rays.

When the voltage applied at the terminals of the tube is known, then the wave-lengths of the rays can be figured out by means of a certain formula. (Planck-Einstein.)

Xrays are very short electro-magnetic waves. They are produced when the electrons of the cathode rays strike the target of an xray tube. The length of the waves depends upon the velocity of the cathode rays. Cathode rays are generated when a high-tension electric current is applied to a bulb, from which the air has been exhausted. They are formed through the breaking up of the atoms of the gases still remaining in the tube. When the cathode rays strike matter Roentgen rays are produced. (Impact radiation.)

There are now instruments of precision by means of which the wave-lengths or

those arising from radioactive substances can be accurately measured. The unit of measurement is called an "Angstrom," which is one hundred millionth part of a cm.

There are two types of tubes which are used to generate xrays, i. e., the gas tube, in which the cathode rays arise from the breaking up of the gas atoms in the tube, and the gas-free tube invented by Dr. Coolidge, of the General Electric Company. In the gas-free tube the cathode rays arise from the electrons liberated by a heated Tungsten spiral. The point at which the Roentgen rays arise is the same in both types of tubes and that is, the so-called focus of the anticathode, at which the cathode rays strike, and at the point of impaction xrays are generated. The intensity of the xrays diminishes, as does light from any source, as they leave the focus, according to the law of squares.

The first knowledge of the biologic action of xrays was acquired through the sad experience of the early workers. It was found that the rapidly growing cells would be destroyed, while the normal cells would suffer no injury, and it was this phenomenon, which lead to the application of this physical agent in the treatment of neoplasms.

A very important characteristic of Roentgen rays is that when they strike upon matter, new Roentgen rays are formed (scattered rays), which possess all the characteristics of the primary rays, from which they originate. Scattered radiation is of great importance in deep therapy. The larger the portal of entry the greater is the number of scattered rays; the shorter the wave-lengths of the primary rays the greater the number of scattered rays. With rays of the shortest wave-lengths and large portals of entry, the scattered radiation amounts from 20 to 30 per cent., 10 cm. in the depth. With soft rays used in the old method of therapy, the scattered radiation was negligible.

When a beam of rays, issuing from an xray tube, enters the human body, a part of it is absorbed in the tissues and another part travels on in other directions in the form of scattered radiation. The intensity of the radiation gradually diminishes in the depth. Dessauer and Vierheller have worked out a series of about sixty charts, showing the depth distribution of the sum of the primary and scattered rays. The measurements of these charts were made

*Read at the regular meeting of the Passaic County Medical Society, at Paterson, N. J., April 10, 1923.

on a water phantom. The absorption of x-ray energy in water is about equal to that in the human tissues.

The end result of the action of Roentgen rays upon every type of living cell is death of the cell. However, the necessary amount to produce cellular destruction differs with different types of cells. Some cells are less and some more susceptible. The higher the metabolic function of the cells the greater their susceptibility to radiation. The rapidly growing cells are most susceptible to rays. The basal cell epithelioma requires a smaller dose than does the squamous cell epithelioma. The cells of a tubercular gland require a higher dose than do the cells of a Hodgkin's gland. Sarcoma is more susceptible than carcinoma. Lymphosarcoma responds well to 40 per cent. of an erythema dose. Uterus sarcoma requires from 70 to 80 per cent. of an erythema dose. Bone sarcoma requires 120 per cent.

We know that continuous irritation of the skin by Roentgen rays may result in cancer. We also know that another dose will stimulate cancer to further growth, and we further know that still another dose will cause death of the cancer cells. Between the last two values lies the dose, and that is a magnitude of Roentgen energy, which, on the one hand, will not stimulate the cells to more rapid growth, and, on the other hand, will not be large enough to produce cellular death. Briefly speaking, the biologic action of Roentgen rays, depending upon the quality and quantity, will, in certain doses, have a stimulating effect upon all cells, and in another dose an inhibitory effect, and still in another dose a destructive effect.

The most important factor in deep therapy is to deliver into the depth a qualitative and quantitative homogeneous radiation. The beam of rays issuing from a Roentgen tube consists of a heterogeneous mixture that is rays of various wavelengths. In order to produce a practical homogeneous radiation, a substance that will absorb the soft rays is interposed between the patient and the x-ray tube, and that is what we term filtration. In modern deep therapy, where voltages ranging from 200,000 to 250,000 are applied at the terminals of the tube, metals of high atomic weight are necessary for filters. The higher the atomic weight of the filter used, the greater is the number of scattered rays. The most practical metals for this purpose are copper and zinc.

What constitutes an effective dose for different types of cells and how to deliver such dose, 10 cm. deep or more, has been the most difficult problem to the physicist and Roentgenologist. The table worked out by Seitz and Wintz, which is based on extensive experimental work, is very useful, but should be applied with great caution. The table is as follows:

Skin unit dose, 100; castration dose, 35; sarcoma dose, 60 to 70; carcinoma dose, 90 to 110; irritation dose, for carcinoma 35 to 40; intestinal dose, 135; muscle dose, 180; tuberculosis dose, 50.

We know that the intensity of a beam of rays weakens gradually, as it traverses in the depth. The nearer the target of the tube is to the skin, the more perceptible is the loss of the energy in the depth. To correct for this loss the focus skin distance is increased. Increasing the focus skin distance, the time of exposure must be increased, according to the law of squares. If, for example, at 25 cm. focus skin distance an erythema dose is obtained in thirty minutes, and if we now increase the focus skin distance to 50 cm., it would take 120 minutes to deliver an erythema dose. The economical loss encountered through the increase in time is well compensated by the gain in percentage of the radiation in the depth. The further we remove the source of radiation, whether it be an x-ray tube or a radio active substance, the nearer does the depth dose approach the skin dose. With portals of entry 20x20 cm., focus skin distance 50 cm., and a voltage of 230,000, the effective dose, 10 cm. deep, is about 45 per cent. of the skin dose. To obtain a higher percentage in the depth, cross-firing is made use of. For example: We wish to treat a carcinoma of the uterus; we give an erythema dose from the front, and an erythema dose from the back, and we have applied to the uterus and its adjacent structures about 90 per cent. of the skin dose. But, we want to deliver to the tumor 110 per cent., so the balance may be given through a smaller portal of entry and a shorter focus distance from the sides, still better, by introducing into the uterus a capsule of radium. The treatment of benign tumors is somewhat easier, when compared to cancer, as it is not necessary to give an erythema dose in the depth in such cases, and not very much harm can be done by underdosing. But, to give in a malignant neoplasm a small dose is very dangerous, as that may stimulate the tumor to more

apid growth. A tumor that once received small dose becomes refractory to further treatment.

The biological explanation of the effects of radiation on the cell is still unsolved. Several theories have been advanced. Schwarz found that after raying eggs, the yolks decomposed and that the decomposition was due to alteration of the lecithin content of the yolk. Lecithin being an important constituent of animal cells, an alteration of the same might retard the further development of the cell. The Hertvigs demonstrated microscopically that the chromatin of the cell is directly injured by radiation. Holthusen maintains that it is the secondary Beta rays, which are set up in the tissues, that produce the biologic effect. There is reason to believe that the action of radiation is not entirely local, but systemic, as well. Cases have been observed where metastasis have completely disappeared, following an irradiation of a primary tumor far removed from the metastatic growth. Such effect may be produced by secondary radiation set up in the iron content of the hemoglobin.

The modern deep Roentgen ray therapy inaugurated by German physicists and Roentgenologists, about eight years ago, consists in giving massive doses of the hardest possible rays. Unless there are contra-indications, the entire dose is given in one session. This necessitates exposures lasting from six to ten hours. This technique, if carried out properly, with as high a voltage as possible, and homogeneous radiation to all parts of the diseased tissues, a lethal dose can be applied in one session. Of course, great care must be exercised in selecting the cases for such treatment. Cachaxia, enemia and general lowered vitality are contra-indications for the massive treatment.

The results thus far obtained in the clinics of Freiburg, Erlangen, Frankfurt and Berlin are very encouraging. Their statistics show that a large series of patients, who were hopelessly inoperable, were restored to good health, lasting for several years. Wintz reports about 3,000 cases of cancer of the uterus radiated in the last seven years, approximately 500 of these were cancer of the body of the uterus; 70 per cent. showed arrest of the disease over a period of four years. Dr. Wiesel, of Vienna, told me personally, that of 140 cases of primary neoplasms in the chest, treated by him with massive doses in the last seven years, he saw only six recurrences. Dr. Case, of Battle Creek, Mich.,

who has treated a large number of inoperable gynecological cases with the German technic in the last two years, states that the results he obtained are *most* encouraging.

This new method of deep Roentgen therapy is yet young. More time has to elapse until the final verdict can be rendered. Should researches continue in the future, as in the past, opening wholly new channels, there will be reason to hope that the problems yet unsolved will in time be fully realized. Along with this there will come safer methods as to the manipulation of the now still dangerous weapon of the Roentgen rays, to be employed in the struggle against the most destructive diseases afflicting suffering mankind.

THE CAUSES AND PREVENTION OF DEFORMITIES OF THE PELVIS

By B. Franklin Buzby, M. D.,
Camden, N. J.

In the presentation of this subject I shall not attempt to bring forth anything new, but rather I shall confine my remarks to an anatomical review of the various deformities of the pelvis, causing dystocia, with special emphasis on those causative agents over which we, as doctors, have control. Using as a classification that of Hart, published in the Edinburgh Medical Journal of August, 1917, I shall attempt a modest elaboration of this, and so broadly divide the types encountered into the congenital and acquired malformations of the bony pelvis.

The frequency of occurrence of all types of deformed pelvis varies greatly, according to individual observers, but apparently the condition is three or four times as frequent in negroes as in whites, and more frequent in Europeans than in Americans. Williams gives 8.5 per cent. for whites and 32.6 per cent. for blacks in a series of 4,750 cases at Johns Hopkins. The diagnosis and methods of delivery in the various deformities I shall leave to be discussed by those better versed than I am in obstetrics.

According to Hart's ideas, the first two sub-divisions are distinctly congenital, and aside from being of interest as to causative agents and the condition present, the problem is, from babyhood on, one for the obstetrician. These two divisions are (1) where the pelvis is uniformly involved in the change, and (2) where there is a loss

or absence of determinants for the development of individual portions of the pelvis.

In the former, two distinct types of malformation are encountered—the justo-minor and dwarf pelves. Both these are usually equally and generally contracted, but can be differentiated by the fact that by xray examination in the true dwarf type all the epiphyseal cartilages persist, while in the justo-minor type ossification is complete, and it is really a miniature normal pelvis. In the latter division we find many kinds of severe deformities, but fortunately all are rather uncommon. Each of the following malformations is manifested by some mal-development of portions of the pelvic ring:

1. The obliquely contracted or Naegele pelvis. Here one of the sacral alae is completely or partly missing, but a firm synostosis exists between the sacrum and ilium. This missing segment causes the ilium on the affected side to be pushed upward and inward from the acetabulum, with the crest elevated. The sarco sciatic notch is narrowed on the affected side, and the symphysis pubis is displaced toward the normal side.

2. The transversely contracted, double-Naegele, or Robert pelvis, in which both sacral alae are absent or only partially developed. This absence causes the transverse diameter to be distinctly narrowed, while the anteroposterior diameter is normal or nearly so.

3. The split pelvis, which is due to a failure of union of the pubes at the symphysis. This is accompanied by a flaring of the ilia, as a result of lack of median fixation. As a rule this pelvis is enlarged, but when dystocia is present it is the result of lack of muscular and bony support anteriorly.

4. High and symmetrical assimilation of the sacral promontory, the funnel pelvis, due usually to the presence of six instead of five sacral vertebrae. This causes the lower pelvic walls to converge, because of altered relations of the sacro iliac joints. This type of funnel pelvis is entirely different from the same deformity seen in rickets, and as a rule it is not recognized by external examination alone.

5. Loss of determinants for the sacrum. This is very rare. The sacrum is almost, if not, completely lacking and there is a marked lessening of the transverse diameter, the lumbar vertebrae articulating with the posterior superior spines of the ilia.

6. Loss of determinants for the first sacral vertebrae or low assimilation, when complete, is not a cause of dystocia, but when one-half of the assimilated vertebrae retains the characteristics of a sacral and the other half of a lumbar vertebrae an obliquely contracted pelvis results, which is an obstruction.

7. Loss of determinants for the size of all the bones in the pelvis, as evidenced in achondroplasia and cretinism. In the former that portion of the ilium entering into the formation of the ilio pectineal line is under-developed, thus bringing the sacrum much nearer the pubis than normal. In the true cretin the pelvic bones show general imperfect development, differing from the dwarf pelvis in its lack of infantile characteristics, i. e., presence of epiphyses.

8. Non-union of the ossific nuclei of the last lumbar vertebrae, spondylolisthesis. Here the last lumbar vertebrae grows forward and downward on the anterior aspect of the sacrum, thus occupying a part of the superior strait. It is not a luxation, instead is due to a lengthening and thinning out of the inter-articular portions of the last lumbar vertebrae, the so-called spondylolysis. Eventually this deformity causes a rotation of the pelvis to right-angles with the femora, due to a shifting forward of the center of gravity and a compensatory lordosis.

This comprises all of the true congenital malformations of the pelvis, and while many yet to be described are the result of congenital abnormalities elsewhere in the body, still the deformity of the pelvis is secondary to the forces of gravity operating in the presence of soft bones and deformed spines or legs. These so-called acquired deformities are the result of constitutional or local disease or malformation elsewhere in the body, and all are acquired during extra uterine life, and many of which can easily be avoided if early and active treatment be instituted to prevent the changes, which will take place. As a part of the constant medical advances, I feel, is this very important matter of the early prevention of deformities, rather than after the changes have become fixed, to call on an orthopaedist for help, who, at this stage, can be of little or no aid in preventing a surgical procedure for delivery, with the prospect in many cases of a dead infant, and all too frequently of a permanently disabled or dead mother.

These acquired deformities are brought about in many ways and by different mechanisms, and upon the means of pro-

duction are based the further sub-divisions.

1. Disturbed and increased or absent leg resistance, due to such conditions as club-feet, congenitally small and deformed legs, dislocated hips, amputations, tuberculosis of hips and to contractures resulting from infantile paralysis. The types of malformations following any of these conditions may roughly resemble any deformity occurring in the bony pelvis, from local or constitutional disease. In club-feet, especially in unilateral, untreated cases, there is atrophy of the foot and leg and frequently shortening as well, which causes a limp and a twisting of the pelvis, due to increased upward pressure on the sound side, and so in young, soft bones this deformity becomes osseous and fixed. There is also a compensatory spinal curvature, which aids by muscular pull in twisting the pelvis. How much more rational it is to treat this underlying condition properly, as soon as the child is born, so that when it begins to walk, its feet will be practically normal, and secondary pelvic deformities prevented. The same dictum holds true in congenitally deformed legs, regardless of type. Early correction of these conditions is essential, and if appliances to overcome shortening are prescribed, as indicated, leg resistance will be equalized and no pelvic deformities will result.

In congenitally dislocated hips early correction is indicated, as it is in club-feet, for two reasons, it is better for the patient's future and very much more easily obtained. The changes taking place in the pelvis, as a result of this condition, are because of misdirected bony pressure, improper posture, and in unilateral cases, as a result of shortening on the affected side. The femoral heads naturally rest in the acetabulum, which has proper bony reinforcements to carry the body weight. If this weight has to be borne behind or above the acetabulum in the thin ilium in soft bones, a false acetabulum will be formed by mesial pressure, and so will the superior strait be narrowed laterally. Again a patient with this condition has the center of gravity forward, as in spondylolisthesis, and a lumbar lordosis develops, with a tilting of the pelvic planes and a pushing forward of the promontory and backward of the coccyx will ensue. Shortening again causes oblique deformity, due to lack of leg resistance and secondary scoliosis. In amputations, without prosthetic appliances, there is a drooping of one side of the pelvis and, due to the lack of support, rotation

and oblique contracture occurs, yet how many females do we see who have lost legs and use nothing for support except crutches.

The mechanism of production of pelvic deformity in tuberculosis of the hip is again imbalance plus atrophy of the pelvic bones on the affected side when the disease occurs very early in childhood. Untreated tuberculous coxitis or those lacking constant supervision are all fixed in adduction and flexion. This fixation is bony if the process has healed, and muscular if not healed. In any event, the pelvis is tilted upward on the affected side, which adds greatly to the apparent shortening. The flexion deformity causes the pelvis to be tilted forward, so that the leg may reach the ground, thus adding to the postural causes of the bony changes.

We expect most of the tuberculous hips to be fixed or have greatly limited motion, especially abduction. How much better it would be for that fixation to be in the position of choice, abduction, which is the one aimed at by those of us doing this work, when we have the case under control, for, in addition to lessening the chance of pelvic deformity, this position gives apparent lengthening to the shortened leg, as well as making walking easier and with less limp. In infantile paralysis of the lower extremities if deformities are not guarded against, flexion contractures of the hips occur, and if the child attempts to walk the pelvis will be tilted forward to permit the leg to reach the ground, lordosis will ensue, and following this will be a tendency to a flat pelvis. Adolescent or child patients who are confined to bed for years get what is called a prone pelvis from disuse, which is usually a flat one, although sometimes it is infantile in type. Change of position in bed might prevent the flat type. It is the observation of Merrell, of Philadelphia, that, due to the fact that many women when standing put all of their weight on one leg, the muscular pull on the pelvis is uneven, resulting in a flattening and forward rotation of the ilium on the weight-bearing side and a rotation and pulling backward of the opposite of innominatum. This again is a manifestation of lack of support and leg resistance.

2. Overweighting of the pelvis by undue pressure in childhood. This causes the so-called simple flat or flat, non-rachitic pelvis. In this type pelvis the sacrum is nearer the symphysis pubis than normal, while the transverse diameter remains un-

changed. This narrowing is most marked at the superior strait, due to rotation. The deformity rarely is pronounced, the true conjugate not being less than 8 cm., as a rule. The sacrum is not altered in shape. Several theories exist as to its etiology. Europeans hold that it is due to the carrying of heavy burdens too early in life, while in this country it is ascribed to permitting the child to sit up for too long periods at too early an age. Certainly it is not rachitic in origin, as I shall show later by comparison. Again, some observers claim the deformity is congenital in origin. In the matter of prevention, custom in the United States does away with the carrying of heavy burdens by young girls, and our only hope lies in discouraging the over-enthusiastic mother from insisting upon her child sitting erect, while the pelvic bones still can be moulded by weight-bearing.

3. Previous constitutional bony diseases causing pelvic deformity, owing to incomplete resistance of the pelvis to downward body weight and upward leg resistance, as is evidenced in rickets, osteomalacia and tuberculosis of the sacro iliac region. Of these diseases rickets is by far the most frequently encountered, and this disease alone is responsible for several individual types of pelvic deformity. To be sure rickets and osteomalacia are not considered to be such widely separated diseases, still there is a distinct difference. Rachitic bone changes manifest themselves in an osteitis, with excessive formation of bone-like tissue at the epiphyses, beneath the periosteum of long bones, and in the pelvis and skull. However, the calcification in this new bone is deficient, there being about one-third the normal inorganic salts present. Three stages of the disease are recognized: (1), congestion; (2), softening, and (3), cure or progression in deformity. In the congestive stage new vessels are formed in the areas usually affected, and as a result of this new osteoid tissue begins to grow. In the stage of softening this vascularity is greatly increased and the new vessels extend further and more widespread into the new bone, causing it to become very much less dense or frequently completely decalcified. When these changes take place in the shafts of long bones, the true osseous tissue becomes spongy, resembling the cancellous type found normally at the epiphyses. In the last stage if a cure results it is by a decrease in the vascularity and resumption of normal ossification. The bone, however, is

atrophic, and all the deformities brought about by use during the first two stages of the disease are permanently fixed by the recalcification. It is needless for me to review the symptoms and treatment of rickets here, but a word or two as to the prevention of all rachitic deformities I do not consider out of place. Since it is in the first and second stages of the disease that malformations occur it would appear that rest in bed during these periods would be the ideal procedure, since the malformations result from weight-bearing, and if, in conjunction with this, real, true sunshine could be insisted upon as the greatest of all remedial agents, I feel that we would not see so many of the severe types of rachitic deformities that are at present encountered in our orthopaedic clinics. If the progress of the disease has been checked, and there exists already the bow legs, knock-knees and spinal curvatures so common as after-results, these should be cared for at once, before they bring about pelvic deformities, which might not already be present, because of a disturbance of leg resistance and the location of the center of gravity. Early these conditions can be remedied by braces, whereas, if allowed to persist, osteotomies and bone transplantation, for correction must be undertaken.

The various types of pelvic deformities, which may occur as a result of rickets are four: (1), flat; (2), scoliotic flat; (3), flat, generally narrowed, and (4), pseudo osteomalacia. In the flat type the main changes are in the sacrum, which is broader, thinner and less concave on its anterior surface. Due to the accompanying lordosis, the pelvic inclination is increased. The promontory is lower and more anterior than usual, thus decreasing antero-posterior diameter. The iliac bones are generally smaller and more delicately shaped than normal, and the vertical height lessened. Thus is seen a distinct difference from the simple flat pelvis previously described, where the changes result mainly from the sacrum being placed more anteriorly with no intrinsic changes in this bone. In the scoliotic type the deformity results from a primary lateral curve in the lower dorsal or lumbar region, with a compensatory curve in the cervical or upper dorsal region of the spine. In the compensatory curve is seen in the lower dorsal or lumbar vertebrae, and no pelvic deformity will result. These pelvic changes are similar to those caused by any type of scoliosis, regardless of etiology. In this low type, which causes malformation, the

changes which occur are one side of the pelvis is elongated and the other side compressed and the long axis thus becomes oblique toward the short side. The spinous processes on the compressed side are rotated, thus adding a vertical twist to this long axis. The side of the pelvis toward the spinal convexity is contracted and the superior strait is usually narrowed. This deformity does not involve the inferior strait, and frequently the ischial tuberosities become more widely separated in the rotation.

The most severe type of the more frequently encountered rachitic pelvis is the flat, generally narrowed one. Most of this change is in the sacrum, this being markedly narrowed. The other bones, however, are atrophic. Some men think this type may be primarily a justo-minor pelvis, with the flat rachitic changes engrafted upon it. At any rate all measurements are less than normal. Pseudo osteomalacia, fortunately, is rare as a complicating pelvic deformity of rickets, but, as its name signifies, it is an advanced manifestation of the disease. The sacrum and lateral walls all approach each other, giving it a trefoil-shaped superior strait, due entirely to persistent weight bearing, when the pelvic bones are in a very soft stage of the disease. In true osteomalacia all have practically agreed with Fehling, who advanced the theory that this disease is a trophoneurosis of the ovary, which, in turn, causes either a decalcification of bones, as held by one school or a disturbance in resorption and apposition of bony tissue, as held by another school. At any rate, from a practical point of view, the skeletal bones, particularly the vertebrae and pelvis, become very soft, usually coincident with pregnancy and accompanied by rheumatic pains, difficulty in locomotion and decrease in height of the patient.

The deformities of the pelvis, which occur, are very similar to those seen in rickets, and the severity of which depends on the amount of softening of the pelvic bones. Generally, however, the deformity progresses rapidly until the usual trefoil-shape is present, due to a downward and forward pressure on the sacrum from the body weight above, and an upward and inward pressure on the ilia from the femoral heads. The pubic and ischial rami are approximated, causing a beak-like protuberance at the hymphysis. Once recognized, immediate rest in bed is indicated to prevent extreme deformity from weight-bearing, and castration, as soon as considered wise

by the obstetrician, offers the means for a very brilliant cessation of the disease and progress of the deformity. Tuberculosis of the sacro iliac joints, usually unilateral, can occur at any age, but, like all tuberculous bone and joint lesions, occurs most frequently in younger patients in whom some of the bone marrow is still red. It is always secondary to a focus elsewhere in the body, and causes its deformity by a destruction of the joint and contiguous bony parts. This is accompanied with or followed by a relaxation of the ligamentous and bony supports and an anterior subluxation of the sacrum on the affected side, with a rotation of the ilia and a shortening of the antero-posterior diameter. Should the process heal, the pelvis would resemble the scolio rachitic type, but with the deformity not so severe.

4. Tuberculosis of the spine, with the pelvis free from disease, causes malformed pelvis, because of two ensuing deformities of the spine itself: (1), kyphosis, and (2), kyphoscoliosis. In carious kyphosis, where the hump is in the dorsal region, no pelvic deformity results, due to the compensatory lumbar lordosis. Its chief effect is noted where the kyphosis is in the low dorsal and lumbar locations, and the nearer the pelvis the more severe is the resulting pelvic deformity. The most serious change that occurs is the rotation from before backward of the sacral promontory, and from behind forward of the tip. The entire sacrum is elongated and narrowed from side to side. Each innominate bone is rotated, the iliac fossae are flared and the tubercles of the iliac fossae are turned in toward the mid-line. This gives a funnel-shape to the pelvis. When the disease is at the lumbo sacral joint the rotation of the sacrum is most marked, and in addition the lumbar vertebrae may so overhang the superior strait, due to the destruction of the vertebral bodies, that the child's head is prevented from entering it, giving us the so-called pelvis obtecta. In kyphoscoliosis, depending on which element of the curvature is predominant, the deformity of the pelvis may be that just described under kyphosis, or that described under the scolio rachitic type. The mechanism of production is the same in each. When these two deformities are of equal severity, the predominant changes are those due to the kyphosis. The prevention of these secondary pelvic changes is in the prevention of the primary tuberculous deformity, which, to generalize such a vast and important subject, consists in rest in bed, extension and hyper-extend-

sion and general hygienic measures, including direct exposure of the bared part to the sun's rays and later external fixation by braces or casts or internal immobilization by a bone operation, or both.

5. New growths spring from the pelvic walls and may consist of bone, cartilage or fibrous tissue and may be benign or malignant. Enchondromata are the most frequently encountered, and any of the benign type may be symptomless. For some reason these tumors grow much more rapidly during pregnancy, and the prognosis is bad for mother and child, regardless of the operative procedure attempted for delivery. Like tumors elsewhere, no prophylactic measures are known.

Deformities following fractures severe enough to cause dystocia are rare, due to the fact that in most severe types the patient usually succumbs to the injury. Any type of deformity might occur, however. Since the deformities, which I have described under the term acquired, are by far the most frequent, what a great good could be done humanity by our profession as a whole by earlier and more active treatment of the causes.

CANCER OF THE PANCREAS; REPORT OF CASES

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Camden, N. J.

Cancer of the pancreas—including secondary tumors—is not so rare, although primary cancer in this organ is not nearly so common as is thought by some writers.

Soyka, for instance, among 3,950 autopsies found 313 carcinomata, of which three (1 per cent.) were primary in the pancreas. Primary cancer of the pancreas has been reported by Maxson, Russel, Bourke, Fowler, Gelle, Porrini, Fabozzi, Allyn, Kesteren, Gade, Hale, White, Aigner, Goldstein, Finnel, Kuhn, Fothergill, Mirallie, Oser, Bandelier, Kidd, Lachmann, Abbe, Cimballi, Councilman, Dutil, v. Hauff, Pott, Losch, Herringham, Johnson, Mayet, de Massary, Miller, Ruggi, Salles, Seebohm, Stein, Strumpell, Wagner, Zeri and others. During the past year I have seen four cases of primary cancer of the pancreas.

Oser, of Vienna, states that: "Primary cancer of the pancreas is by no means a

very rare disease. Secondary carcinoma is far more frequent." More than ten per cent. of the metastases after cancer of the stomach affect the pancreas. Sarcoma of the pancreas is very rare. In a paper in the American Journal of Surgery (February, 1922; 36; 23-29), I collected cases of primary sarcoma. The head of the pancreas is the most frequent seat of the neoplasm. In thirty-two cases of primary pancreatic carcinoma at the Vienna General Hospital, the tumor was in the head in twenty cases.

The most frequent form is the fibrous cancer with hard, dense nodules. Sometimes the tumor attains a large size, weighing two or three pounds or more; while at times the pancreas appears smaller than normal and atrophied. Very often the bile ducts, gall-bladder, liver and stomach are also involved.

In my paper on "Cancer of the Pancreas," in the New York Medical Journal and Medical Record, December 20, 1922, I discussed the symptomatology and reported a case of primary nodular cancer of the pancreas in a white woman, aged 57 years. I will now only briefly refer to some of the more common symptoms and report two additional cases of primary carcinoma of the pancreas.

Disturbances of digestion generally occur early, distress after eating, fullness in the epigastrium, belching, nausea, heartburn, diminished appetite, sense of pressure and some pain. Sometimes, however, the appetite continues to be very good. Later, vomiting and severe pain occurs, together with the appearance of *jaundice*, which gets progressively worse. There may be marked changes in the gastric juice, with a lack of free hydrochloric acid. Often, however, the gastric contents may show normal findings and be entirely negative. Of course, when dilatation of the stomach occurs, due to compression of the duodenum or pylorus, vomiting occurs and there is an increase in disturbances of digestion.

Fatty stools may be noticed. Duodenal contents may early show a lack of pancreatic enzymes. Here the use of the *duodenal tube* may be of considerable diagnostic aid. Einhorn, of New York, emphasizes this use of the duodenal tube. Oser mentions a case in which fatty stools were present to quite a degree. Another case is mentioned in which one-fourth of the weight of the stools was due to fat.

There is, of course, disturbed digestion of proteids, as well as starches.

Bulky stools often occur, because the food, in good part, passes out undigested.

Clay colored (acholic) stools, due to bile obstruction, is often noted. Blood may also be present.

Pain is often very severe, and usually continues throughout the course of the disease. The pain may radiate to the back, shoulder, and to the upper right hypochondrium.

Jaundice may be the very first symptom that brings the patient to the physician. This is followed by rapid loss of weight and symptoms of disturbed digestion.

On examination, the gall-bladder is nearly always found to be distended and readily palpable. This is an important diagnostic point, because in *jaundice*, due to a calculus in the common duct, the gall-bladder is usually atrophied and shrunken. However, there are, of course, many exceptions to this rule. Cabot found the gall-bladder distended in only two cases of a series of fifty-seven cases of calculus.

Other symptoms may be ascites and edema; *cachexia* is rapid and present quite early in many cases (*cachexia praecox*). Polyuria, glycosuria, albuminuria may be present. Many cases of pancreatic cancer, however, do not have glycosuria.

Finally, *tumor* in the epigastrium is palpable, sometime before the end, in a small proportion of the cases. This mass would be fixed, while a cancer of the pylorus or colon would be movable.

Cases of cancer of the pancreas have been reported and discussed by Wells (1922), Loeper (1919), Gorke (1922), Sachs (1918), Schmidt (1916), Ochsner (1920), Koetlitz (1920), Fowler (1920), Adler (1921), Adams (1921), Mussey (1919), Speed (1920), Serafini (1914), Silvan (1915), Stewart (1915), Bourke (1914), Brentano (1914), Chavannaz (1913), Deaver, Gayet (1914), Secousse (1914), Allyn, Fabozzi, Swain, Ravenna, de Verbizier, Parkinson, Quadrio, Marmorstein, Jones, Chaffard, Allen, Kusama, Pauly, Spillman, Maclaure, Lepine, Jaboulay, Dehon and others. Papers on the subject have also been written by Sabrazes, Fuchs, Grimani, Rochard, Willard, Hulst, Hustin, Hancock, Villar, Stander, Gabbi, Bell, Auché, Andrews, Brosch, Hancock, Etienne, Bokitko, Vandervelde, Viscontini and Wiliamowski.

CASE REPORTS.

From the Philadelphia General Hospital.

Henry N. J.—Admitted, 11-6-22; died, 11-12-22. Service of Dr. L., N. Boston;

diagnosis, abdominal malignancy (probably carcinoma of sigmoid) tympanitic ascites.

Chief Complaint—"Gas in stomach."

History Present Illness—Three weeks ago (10-15-22), on account of distended abdomen, accompanied by dull, aching sensation from pressure; patient gave up his vocation (music teacher) and sought medical advice, but has not been in bed at any time. Appetite was fair until ten days ago, since which time there has been no desire for food, and that taken (mostly milk) has caused increased abdominal distress, noted particularly about the umbilicus. This pressure distress has been present for past three weeks, worse after drinking milk, but not relieved to any great extent by defecation or flatus. There is occasional belching; no emesis and at no time hematemesis.

Family History—Father died of Bright's diseases; aged seventy; mother died of debility; aged sixty-nine; one sister died; aged eleven, diphtheria; one sister died; aged sixty-five; cause, unknown; three sisters died in early life. Married for forty-five years; wife died of apoplexy, aged fifty-nine; no miscarriages; one son died at age of forty-one, neuritis; one daughter living and well, aged forty-three.

Past Medical History; General—There has been a gradual decline in weight from, at maximum of 150, to a present weight of 116. The decline has been slow, never any decided changes. Vocation of violinist followed until Oct. 15, '22, three weeks before admission. Mentality, good.

Respiratory System—During childhood, at 12, patient had a bad cold, pain in chest, expectorated blood-streaked mucus, and had night sweats for a period of two weeks. This condition seems to have been transient. No other symptoms referable to lungs, except, perhaps, pleurisy at one time during middle life.

Circulatory System—For past five years (1917), from time to time, there have been specks before the eyes and some dyspnoea on exertion, but not enough to cause much inconvenience. For past three years there have been vertigo and cephalgia of a dull, aching character, occurring either in day or night, and not referable to reading. From time to time, for three years, there has been a tingling sensation in tips of fingers of left hand. None in right hand nor feet. For past ten years there has been a very occasional, dull, aching pain over pericardium, seemingly independent of exertion. No palpitation; no syncope.

Gastro-Intestinal—First evidence of abdominal discomfort was noted fifteen or

eighteen years ago. Stomach—Only a little food would feel overloaded, but there was no abdominal distention. No sharp nor gnawing pains, simply a feeling of inflation without external discomfort; would terminate spontaneously each time, after two or five days, until the present attack, which has persisted for past three weeks. Appetite has been good, or at least fair, until two weeks ago (Oct. 23, '22), since which time there has been anorexia, continuous distention and discomfort, slightly exaggerated by food. Never constipated.

Genito-Urinary—Gonorrhea, twice aet., 25 and 35; was apparently cured. No urinary disturbances. Nocturia, 2-5 times for past three weeks. Chancre aet., 40. No secondary eruption.

Nervous System—Headaches for past three years. Tingling in fingers of left hand for three years.

Habits—Chews tobacco; does not smoke. Has been drunk; has drunk moderately, mainly beer. Has had a dozen glasses of beer in a day, average was 2-3 glasses for period of fifteen years. Abstainer for past two or three years.

Admission note, Nov. 7, '22.

Patient markedly emaciated; apparently in no severe distress. Heart rate, rapid. No adventitious sounds. Tic-tac tendency. No edema. Markedly distended abdomen.

Impression—1, Primary malignancy (probably stomach); 2, metastasis (to liver); 3, emaciation; 4, ascites and marked tympanites; 5, partial obstruction (portal); 6, senility; 7, arteriosclerosis.

Nov. 7, '22. Rectal examination revealed a normal-sized prostate; not hard or nodular, as in carcinoma. No palpable internal hemorrhoids. No external piles.

Physical Examination; General—Very emaciated, old, colored man, who has a deep pigmentation of his face and hands. His body is almost white. Hair is gray. He is extremely weak; lies in bed with his abdomen distended like a drum and the umbilicus bulging. Defecation is impossible, except an occasional small amount of enema.

Head—Pupils react well to light and accommodation. Teeth all extracted. Marked sublingual petechial hemorrhages, the result of venoarteriosclerosis.

Neck—Negative.

Heart and Lungs—No pathology present.

Abdomen—The abdomen is very distended and the umbilicus bulging. There is only very slight bulging in the glands.

The note on percussion is tympanitic, but the flanks are dull. This dullness shifts

with changes of position. The ascites is not marked. The liver is markedly enlarged, and several very hard carcinomatous buttons or nodules are easily palpable, just below the ensiform, and another two-finger breadths below the costal margin on the right edge of the rectus muscle. The liver is enlarged to about four-finger breadths below the costal margin. There is also very extreme pain on pressure over the umbilicus. No masses palpable in the lower abdomen, but, due to the fact that there is such a marked distention of bowel and also inability to pass feces, I believed the obstruction, malignant in nature, is in the caecum or somewhere low down in gut. Dr. Boston did not think a caecostomy justified, because of condition of patient.

Extremities—Patient complains of pains in both feet. Extremities very thin. Reflexes, normal.

Nov. 8, '22. Patient was much weaker this morning, following the preparatory treatment for xray and fluoroscopic examination. Weakness was extreme, as shown by patient's facial expression and the lack of tone in his muscles. Pulses were very weak, easily compressible, and of very poor tension. Xray request recalled. No bowel movement today, except an effectual enema.

Nov. 9, '22. Patient continued today in about the same condition, as yesterday. He complained of severe pain in the left foot. This is probably due to metastasis into cord, or from pressure of mass on nerves. No external bowel movement this morning. Marked distention of abdomen, due to tympanites and small ascites. Patient at this time has hiccough, which, however, does not seem to cause much distress. Hands are cold and dry. He states, however, that he is warm. Temperature gradually going down far below normal.

Nov. 12, '22. This patient was in a very severe condition when admitted. A bad prognosis was made in the beginning. Only a small amount of feces were obtained, and these by enemas. All measures known were used to relieve the tympanities, with only partial results. Patient died of gradual weakening and cardiac failure.

Final Diagnosis—1, Carcinoma of caecum; 2, tympanites; 3, ascites; 4, arteriosclerosis; 5, intestinal obstruction; 6, bronzing of head and hands; 7, low blood pressure; 8, subnormal temperature.

Autopsy No. 7163, 11-11-22, performed by Dr. Schochet, eleven hours after death. Male, black, aged seventy. Clinical diagnosis: Abdominal malignancy. Bacteri-

ological diagnosis: Heart blood, B.-coli communis.

Gross Anatomical Diagnosis—

Heart—Chronic valvular endocarditis; fibrosis; brown atrophy.

Lungs—Terminal congestion; hypostatic pneumonia.

Spleen—Chronic splenitis.

Kidneys—Arteriosclerotic organs; chronic diffuse interstitial nephritis. (Yellow areas not determined).

Liver—Cloudy swelling; fatty degeneration; implantation carcinoma.

Pancreas—Carcinoma of head.

Histological Diagnosis—

Tumor—Carcinoma.

Kidneys—Arteriosclerosis; chronic interstitial nephritis.

Liver—Cloudy; swelling.

Cause of Death—Carcinoma of pancreas.

External Examination—General Statements—Poorly developed and poorly nourished adult, male, seventy years old, measuring 165 cm. and weighing 104 pounds. Ears, eyes and nose, negative. Teeth, badly decayed; several missing. Chest, negative. Rigor and liver present. A large, firm mass may be felt in the upper part of the abdomen. Genitalia, negative.

Internal Examination—Abdomen—Paniculus averages $\frac{1}{2}$ cm., it is fibrous. Muscles, flabby and fibrous. Peritoneal cavity is covered with numerous, implanted, papillary growths, averaging 1 cm. in height. Intestinal viscera is covered by a similar growth. Appendix is negative. There is a large mass in the region of the pancreas; 6,000 cc. of light, brownish, yellow fluid removed. Diaphragm on the right extends to fourth rib, on the left to fourth interspace.

Liver—Weighs 1,250 gm.; external surface is covered over with numerous papillary implantations; section-lobulation, well marked, with yellow periphery. No new growths found in liver substance. Cloudy, swelling, fatty degeneration. implantation carcinoma.

Gall-Bladder—Is covered with similar papillary growths.

Pancreas—There is a large, fluctuating, soft mass in the region of the head of the pancreas, and apparently replacing this organ. It is of a light, greyish, yellow color, with a central necrosis. Carcinoma of head of the pancreas.

Tumor—Four sections of a neoplasm are presented. They very closely resemble each other in structure. Most of the cells are about the size of polynuclear leucocytes, show acid-staining, homogenous cytoplasm

and hyperchromatic nuclei, which vary greatly in size and shape. Many cells show two nuclei. Frequently cells, with from three to six nuclei, are seen. These cells are about three times the size of the prevailing type of cell. There is a fair amount of fibrous tissue, arranged in thick trabeculae, and a lighter connective tissue stroma. Small areas of necrosis are seen occasionally. No tissue recognized as part of normal organ can be seen anywhere. Carcinoma.

CASE II.

From the Philadelphia General Hospital.

James T.—Admitted to the Philadelphia General Hospital, 1-20-23, to the service of Dr. David Riesman; died 1-25-23.

Diagnosis—Carcinoma of liver; secondary obstruction to bile duct. White; aged fifty-two years; born in Ireland.

Drs. Riesman, Patton and Ching.

Chief Complaint—"Yellow skin."

History Present Illness—In August, 1922, patient noticed his skin was yellow and his abdomen was swollen. He consulted a doctor, who treated him, and the yellow color of his skin disappeared and the swelling of abdomen went down. He was feeling well until two days before last Thanksgiving, when same symptoms appeared again, except at this time there was no itching. He noticed his skin was getting yellowish, and two weeks ago, became darker. In the last attack his abdomen became swollen before the skin became yellow.

He was told by his doctor that he had a large liver. His feet were not swollen last August, but became swollen in the last three weeks. Shortness of breath developed in the last three weeks. He was able to work until three weeks ago. Patient noticed his stools were dirty white last August, and they have been in that color ever since. His urine is brown and has been in that condition since August. He has belching of gas at times. He never has pain in his liver region or in his shoulders.

Past History—Medical—Measles and mumps. Had malaria years ago. Once in a while rheumatism in his right leg. Never had pneumonia, pleurisy, influenza or typhoid fever.

Surgical—None. No rupture; no appendicitis.

Sexual—Single. Denies venereal disease.

Urinary—Micturition, 4-5 q. d. No nocturia. No burning on urination.

Gastro-Intestinal—Good appetite and bowels regular.

Social—Born in Ireland, came to United States in 1893. Has been a fireman in factory for twenty-five years. Has alcoholic habit for twenty years. He would take two glasses of beer and a glass of whiskey every day until two years ago. Since then he has been drinking "off and on," when he could obtain liquor.

Family History—Father died of old age. Mother died of blood poisoning. One brother died of blood poisoning, due to a spider's bite. One sister and three brothers living and well. There is no history of cancer, tuberculosis, fits or insanity in the family.

Jan. 22, '23. Status praesens—

General Appearance—Fairly well nourished white male of about fifty, evidently exhausted and very deeply jaundiced. Speech is slow and somewhat apathetic, but mentality is good. Enunciation is not clear.

Head and Neck—Extreme jaundice of whole head (also of entire body).

Eyes—No nystagmus, palsies nor exophthalmus. Pupils are equal, somewhat irregular, but react to light and accommodation.

Nose and Ears—Grossly negative.

Mouth—Teeth are covered with black film. Tongue is heavily coated with blackish film. Tonsils, normal. Uvula, much shrunken. Pharynx, dry with blackish film. No adenopathy. No venous pulsation. Thyroid, not palpable.

Chest—Full, whole skin is deeply jaundiced. Lower border bulges, because of distention below. Few moist rales posteriorly. Very little respiratory embarrassment. Sullness, as per chart.

Heart—Lies horizontally in chest, as per diagram. First sound is replaced by a soft systolic murmur. Second sound slightly accentuated. Apex beat plainly visible in line with, but 3 cm. above nipple.

Abdomen—Girth, forty-eight inches; liver, palpable. Spleen enlarged, diagrammed by auscultatory percussion. Movable dullness in flanks; shifts 11 cm., with change of position. Some edema of wall in flanks.

Extremities—Edema up to hips. Some clubbing of nails, with cyanosis, and jaundice of hands. Distinct yellowish discoloration of toe-nails. No tremor.

Reflexes—Biceps and triceps, normal; knee-jerks, normal.

Impression—1, Syphilis of liver (hypertrophic); 2, malignancy, with metastasis to

liver; 3, endocarditis; 4, pleural effusion, especially on left; 5, ascites; 6, edema; 7, hydrothorax.

1-22-23. Paracentesis, 8,250 cc. of golden, yellow fluid removed. In container color is dark, rich red. Nodular liver is much more easily palpated now. Patient feels more comfortable. However, there has been no respiratory embarrassment.

1-24-23. During night, patient vomited about oz. VIII of dark-brown fluid; same has been sent to laboratory.

1-25-23. Final Note. Patient continued to vomit, as above; complained of pain in epigastrium. Died at 3:55 a. m.

Diagnosis—1, Secondary carcinoma of liver; 2, carcinoma of head of pancreas; 3, bilateral hydrothorax, as per diagram; 4, obstruction to common bile duct. Immediate cause of death, toxicity, from extreme jaundice.

Urine Analysis—1-22-23. Deep yellow; slight sediment; acid reaction, 1,020 sp.gr.; sugar, negative; trace albumin; bile, positive-hyaline casts, few; leukocytes, few; crystals uric acid; mucus, slight; epithelial cells, few; miscellanea, heavily pregated.

1-22-23. Alkaline reaction; sp. gr., 1,020; sugar, negative; slight cloud of albumin; many hyaline casts.

Blood Analysis—1-22-23. Blood chem. Urea, N., 49; sugar, 107; chlor., 470; creatinin, 3-8; uric A., 3-9 mgm.

1-22-23. Blood Wassermann, negative.

1-22-23. Fragility test, complete, 24; beginning, 60.

1-22-23. Feces color, gray; occult blood, positive; bilirubin, faint.

1-22-23. Ascites fluid urea, N., 47; uric A., 8; chlorides, 600; sugar, 100.

1-22-23. Ascitic fluid culture, 24 hours, no growth.

1-22-23. Ascitic fluid, yellow; clear; alk., 1,010; alb., 0.6%; cells, per cm., 10; lympho, 58; endo, 42; R. B. C., few; strongly positive for bile.

1-24-23. Vomitus, dark-brown, with mucus; free hcl., 12; total acid, 67; bile, negative; blood, strongly positive; many fat droplets; some yeast cells.

Pathological Laboratory, Philadelphia General Hospital.

Autopsy, No. 7,388, 1-25-23.

Service, David Riesman; performed by Fred L. Hartmann; 12 hours after death.

Name of subject, James Tracey; male, white, aged fifty-two years; admitted to hospital, 1-20-23; died, 1-25-23, at 3.55 a.m.

Clinical Diagnosis—Carcinoma of liver, secondary; carcinoma of head of pancreas; bilateral hydrothorax.

Bacteriological Diagnosis—Heart blood, hemolytic streptococcus.

Gross Anatomical Diagnosis—Abdomen, ascites.

Thorax—Bilateral hydrothorax.

Heart—Hypertrophy; interstitial changes, coronary and valvular sclerosis.

Lungs—Congestion.

Kidneys—Chronic interstitial-nephritis.

Stomach—Minor lesions.

Liver—Perilobular cirrhosis and duct obstructions.

Pancreas—Carcinoma, with obstruction of the common duct.

Gall-Bladder—Dilatation.

Cause of Death—Carcinoma of pancreas.

Histological Diagnosis—Hypertrophy, fatty infiltration; nephritis, chronic interstitial; arteriosclerosis; chronic tubular nephritis; carcinoma metastasis; adenocarcinoma; spleen, normal; lymph gland, bile; pigmentation.

External Examination—*General Statements*—White male, fifty-two years of age, measuring 170 cm., and weighing 179 pounds; skin shows marked jaundice throughout. Sclerae of eyes markedly jaundiced. No open wounds. A brush-burn over external surface of lower left leg. Subcutaneous and muscle tissues are not wasted. Bony framework good, no deformities.

Internal Examination—*Abdomen*—*Peritoneal cavity* contains 1,800 cc. of bile-stained fluid.

Thorax—Left pleural cavity contains 1,800 cc. of bile-stained fluid. Right pleural cavity contains about 200 cc. of bile-stained fluid.

Heart—Weighs 575 gm.; measures, 12x11x7 cm. It is firm. Epicardium shows no gross changes. Coronary vessels are pitted by sclerosis. Myocardium cuts with slightly increased resistance; is yellowish-red in color. Left ventricular wall averages 2 cm. in thickness; right ventricular wall, 0.8 cm. in thickness. Excess of fibrosis, especially seen at tips of the papillary muscles. Endocardium shows no abnormalities, except marked bile-staining. Valves all appear competent. Orifices measure, aortic, 8.7, and shows marked thickening; pulmonary, 9; tricuspid, 14 cm.

Aorta—Is markedly bile-stained, contains atheromatous plaques; some of which, in the abdominal region, are calcified.

Left Lung—Weighs 640 gm.; measures 25x15x4.3 cm. Organ crepitates throughout; flabby; shows congestion in both upper and lower lobes.

Right Lung—Weighs 390 gm.; meas-

ures 29x18x4.5 cm. It is again the seat of marked congestion.

Spleen—Weighs 390 gm.; measures 17x11x4.5 cm. Capsule is slightly thickened. Organ cuts, with slightly increased resistance. Cut surface is dark-red in color; trabeculae increased in number; follicles are not visible.

Adrenals—Show no gross lesions.

Right Kidney—Weighs 240 gm.; measures 12.5x6.2x3.5 cm. Capsule strips readily, leaving a granular surface, but showing numerous retention cysts. Cut surface is yellowish-red in color; bulges slightly; normal ratio between cortex and medulla, both are somewhat thin.

Pelves and Ureters are open throughout and show no gross lesions.

Stomach—Is moderately dilated and contains a small amount of dark-brownish fluid. Its walls are slightly thickened, but not thrown into rugi. Remainder of G. i. tract shows no lesions, with exception of marked distention of intestines.

Liver—Weighs 8½ pounds; measures 34x25x10.3 cm. It is very hard and firm. Its edges are rounded. Organ cuts with markedly increased resistance. Cut surface is dark-green, mottled with yellow. It shows no definite areas of metastasis, although here and there in upper portion of the organ small, homogeneous, white nodules are visible; these are most likely areas of fibrosis. Bile ducts are markedly distended, and honeycomb liver substance.

Gall-Bladder—Is markedly distended; contains about 600 cc. of dark, turbid bile. Common and hepatic ducts are markedly distended. Hepatic duct, just before it is joined with the common duct, measures 4.5 cm. in diameter. Common duct is obstructed from without, as it comes through the head of the pancreas. The pancreas at this point is enlarged, hard and nodular. The same hardness and nodular condition extends toward the tail of the organ. It cuts with markedly increased resistance; cut surface is granular and cellular, and the smaller areas are irregular in size and shape and appear to be infiltrating into the surrounding fatty tissue. Here and there are small areas of fat necrosis, and retention cysts, containing a clear mucoid material.

Pancreas—The non-neoplastic part of gland shows fatty infiltration, fibrosis and an interesting hypertrophy of islands of Langerhan. Elsewhere there is marked fibrosis and production of atypical glandular acini and atypical small ducts. The cells are epithelial and vary greatly in size, shape and staining.

Lymph Gland—Bile pigmentation.

The above two cases of primary cancer of the pancreas I had the opportunity to study at the Philadelphia General Hospital, and I desire to express my thanks to Drs. Boston and Riesman for permission to report them.

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X-RAY AND CLINICAL FINDINGS IN THE NORMAL CHEST OF THE CHILD

National Tuberculosis Association
Medical Research.

The National Tuberculosis Association some time ago began a new and important phase of its work in an attempt to increase the quantity and character of research work in problems related to its own field in the United States. For this purpose it appropriated \$20,000 and appointed a small committee composed

of Dr. William Charles White, medical director of the Tuberculosis League of Pittsburgh; Dr. Paul A. Lewis, director of laboratories of the Phipps Institute, Philadelphia, and Dr. Allen K. Krause, director of Kenneth Dows Research Fund, Johns Hopkins Hospital, to expend these funds to the greatest advantage.

This committee decided that the best use of these funds would be in assisting researches already under way that held the greatest promise of increasing the practical knowledge of physicians dealing with tuberculosis. This, they considered, would bring the greatest help to those suffering from tuberculosis and the greatest boon to the public, from whom the funds were collected. This plan has been carried out in co-operation with the universities.

One of the researches was an effort to establish the x-ray and clinical findings in the chest of a normal child up to ten years of age. For this problem the National Tuberculosis Association nominated the following groups of roentgenologists and clinicians:

Dr. H. K. Pancoast and Dr. H. R. M. Landis, University of Pennsylvania; Dr. F. H. Baetjer and Dr. C. R. Austrian, University of Johns Hopkins; Dr. H. K. Dunham and Dr. K. D. Blackfan, University of Cincinnati.

The signed reports of these physicians is here presented in two sections, with the hope that they may promote a discussion which will be fruitful in establishing the truth in these two fields.—Philip B. Jacobs, publicity director.

REPORT OF THE CLINICAL DIVISION OF
THE COMMITTEE ON MEDICAL RE-
SEARCH OF THE NATIONAL TU-
BERCULOSIS ASSOCIATION.

The value of roentgenography in determining the presence of pulmonary disease has long been recognized. Studies to determine the roentgenograms of various pathological lesions of the lung have been almost without number, yet much difference of opinion exists in the interpretations of findings, largely because no satisfactory observations have been made establishing the variations that may occur in the normal. To one observer, shadows noted are indicative of disease; to another, they are not evidence of a pathological process; to one, they represent lesions of clinical significance to another, they suggest

changes of no moment. The realization of this unsatisfactory state of affairs was widespread, but it remained for the Research Committee of the National Tuberculosis Association seriously to consider it and to set about to correct the shortcomings.

In the spring of 1920, that committee called together the collaborators in this work and instructed them to set about in ways of their own choosing to solve the problem, extended to them a financial grant and in order that the problem might be a very definite one, asked that the immediate study be limited to a consideration of the chests of normal children, between the ages of six and ten years. The work was begun promptly and a preliminary report was made at the annual meeting of the Association in May, 1921. The findings at that time were incomplete, and because of the then limited observations, no very definite conclusions were drawn. However, the practical need of a solution of the problem was apparent. Study was continued throughout 1921 and the first four months of 1922, and the data independently assembled were jointly discussed to evaluate them. Although each pair of workers carried on its investigations without intergroup consultation, although each approached the subject from a different angle and when first met held views apparently not altogether in accord, it was agreeable to find that an exchange of conclusions disclosed almost a unanimity of opinion. The findings of these six observers—three clinicians and three roentgenologists—are presented to you for your consideration:

Theoretically, the normal child is one of ideal height, weight and development for his age, without subjective or objective evidences of deformity or of disease and without residual changes due to antecedent pathological processes. Practically a normal child is one of average height, weight and development for his age, symptom-free and without signs of disease. Each such individual, in more or less relation to his age, will have been ill more or less often and as a consequence may be expected to show variations from the ideal, not because of present disease, but as a result of residual changes that persist. An appreciation of these facts makes it apparent that the findings, clinical and roentgenographic, in normal children, as we meet

them, will vary greatly from any fixed standards and still must be considered as variants of normal.

* The clinical data dealt with in this report were obtained by careful examination of apparently healthy children, between the ages of six and ten years. All children who showed signs of disease were excluded from the series. Individuals from various strata of society, foreign and native born, residents of urban and of rural communities, school children and children residing in institutions, children exposed to tuberculosis and some without a history of such exposure, children with and without a history of previous infectious diseases, all symptom-free, and of an approximately normal height and weight for their ages, were studied. A history of each individual was recorded, and in making the examinations of the chest care was always observed to have the child relaxed and to see that no cramped or unnatural posture was assumed, for, as is well known, faulty position may lead to findings that cause confusion in interpretation. In addition, a tuberculin test was made on every child. The clinical data were then assembled, and after the roentgenologist had interpreted his plate independently, the clinical and roentgenographic findings were correlated. In all, over 500 children were thus studied, and as a result some definite conclusions seem warranted.

As in the adult, so in the child vocal fremitus is more marked over the right upper chest than over the left. It is generally stated that the percussion note elicited over the lungs of normal children within the age limits under consideration is fuller, more tympanitic, of higher pitch and more resilient than that noted over those of adults, and that frequently the tympanitic quality is quite outspoken, especially over the lower lobe of the left lung. Although in general our observations confirmed this view, we have been impressed by the fact that in an appreciable number of such children the note obtained on percussion over the lungs is indistinguishable in quality from that elicited over the lungs of normal adults and that the usual resilience of the note is lacking. These findings in many instances have an analogue in shadows noted in the x-ray films, shadows indicative of increased density along the

bronchial tree, similar to those seen in the plates of normal adults. This correlation of the findings on physical examination and on x-ray study is more constantly possible in studies of the upper half of the chest. When minor changes, similar to those discovered by x-ray examination of the upper lobes occur in the bases, they usually escape detection on physical examination. In those instances, in which no shadow is found to explain the deviation of the note from the generally accepted one, it is our belief that the lack of resilient quality may be due to a decreased elasticity of the chest wall.

The so-called tympanitic quality of the percussion note over the left base may be increased, decreased or be entirely lacking, depending upon the degree of distention of the stomach or colon, the curvature of the spine, and may likewise vary with the position of the diaphragm or with the posture of the child during the examination. The note over the upper thorax is often the same on the two sides. Kronig's Isthmus averages 5 to 6.5 cm. in width. The lower margins of the lungs posteriorly are at the level of the tenth or eleventh rib and descend from 1.5 to 3.5 cm. during forced inspiration.

A just detectible diminution of resonance over the apical regions is of no significance unless associated with a modification of the breath sounds in those areas or with other abnormal auscultatory findings. It is generally accepted that normally in childhood the breath sounds have a harsh, sharp character, with expiration longer and better heard than in the normal adult. This so-called puerile breathing is physiological, and though it may seem trite, let it be emphasized that this exaggerated vesiculo-bronchial respiratory murmur, especially well heard in the areas overlying the great bronchi (i. e. anteriorly at the level of the first interspace and the second rib, just lateral from the sternal margins, and posteriorly, particularly on the right side, at the level of the second to the fourth spine), is often incorrectly interpreted as evidence of pulmonary disease. An auscultatory finding that has not been pointed out, or at least, has not been emphasized, has come forcibly to our attention in carrying out this study. Just as the full, deep note or higher pitch characteristically elicited by per-

cussion of the child's chest is often replaced in health by a note more like that produced when one percusses the normal chest of an adult, so, on auscultation of a child's normal lungs, the exaggerated or puerile breath sounds may be lacking, and instead the so-called vesicular respiratory murmur characteristically present in adult life is heard. This finding, regarded by us as a physiological variation, has been noted as early as the age of four years and may perhaps occur in younger children. It is more readily appreciated and more often found than the variation in the percussion note just described. In more than 50 per cent. of the children in which this type of breathing was heard examination with the x-ray gave findings like those obtained by a study of normal adult chests. In fact, the agreement of clinician and roentgenologist was so constant that we have come on the basis of these variations to designate the chest of normal children as of "puerile" or of "adult" type. The essential fact to be stressed is that so-called vesicular respiration is heard with great frequency in normal children, and is to be regarded as a variation of normal and not necessarily as an indication of disease.

These variations and those of the percussion note are more generally found in children with a history of infections of the respiratory tract. No satisfactory explanation for this finding is offered. It may be due in part to altered resilience of the chest wall, a suggestion supported by the fact that in some instances in which it was noted, diminished elasticity of the thoracic wall was apparent on percussion. It may stand in relation to variations of elasticity or the parenchyma of the lung. It may be due to a relative narrowing of the lumen of the bronchial tree. It is hardly to be considered evidence of increased density of respiratory tissue, for, theoretically, at least, that should lead to a modification towards bronchial breathing.

Concerning the whispered voice sounds, little comment needs to be made other than to emphasize their loud transmissions often with syllabation over the region of the major bronchi. Auscultation of these sounds over the upper thoracic spine of the children has led to the conclusion that D'Espine's sign as indicative of enlarged tracheo-bronchial

lymph nodes is, to say the least, of doubtful value. In 23 of the children, this sign was elicited without other signs of a mediastinal mass and without any corroborative evidence on x-ray examination. In 3, the sign could be elicited, although from the x-ray plate it might have been inferred that it should be. Eustace-Smith's sign is so generally present in normal children that it is of little or no practical diagnostic worth. The presence of these two signs together with impairment of resonance in the interscapular region is all too frequently made the premises for a diagnosis of tuberculosis of tracheo-bronchial lymph nodes. This is unwarranted for, as indicated, these signs are unreliable evidence of a pathological condition and the determination of a diminution of resonance in the interscapular region requires such a nicety of technic that even masters of percussion disagree as to the presence or absence of significant findings in this region of the chest.

A year ago, in the preliminary communication to this society we stressed the importance of the role that antecedent infections might play in the production of areas of increased density within the respiratory tract. (Bronchial tree, parenchyma of the lungs, etc.) This fact is reemphasized, for further study has established the importance of it. Not only may recognized or remembered infections of the bronchi and lungs be responsible for alteration in these tissues, but other diseases not ordinarily considered of significance in this regard may be causal of such changes. For example, our observation indicate that after measles, pertussis or tonsillar infections, areas of increased density radiating from the hilum into the bases especially, occur with great frequency. Such lesions generally are not discoverable on physical examination and would be unsuspected but for the use of the x-ray. They are referred to in the clinical part of our joint report in order to point out the need of a careful history as well as examination in all individuals, before proceeding finally to interpret the findings of the Roentgenologist. By way of digression, it may be interesting to point out the fact that though measles and pertussis have been known to produce lesions in the upper air passage, involvement of the lower tract has been considered a complication and was thought to occur only

when evidence of bronchitis or of broncho-pneumonia were discovered. Our observations indicate that there may be a mild inflammatory process throughout the respiratory passages in a large percentage of the so-called uncomplicated cases of these diseases. This suggestion warrants further study in relation not only to the infections under consideration but also other infectious diseases. The shadows mediastinal and basal noted in children who give a history of uncomplicated measles and pertussis are evidence of healed processes is evidence by the experience that similar shadows of like origin have remained unchanged and without the development of clinical symptoms in a series of children observed from 3 to 5 years. Such changes must be properly evaluated as indices, not of present disease, but of lesions past and healed, not as warrant for the diagnosis of present illness and the institution of treatment, but as scars of infections met and overcome.

Most of the children included in this study were tested with tuberculin—some were given a cutaneous test with old tuberculin (Pirquet)—others were tested by the intracutaneous method. (Craig.)

The foregoing facts have been detailed at some length to establish the major thesis that, clinically, the ideal, normal child is a hypothetical impossibility. Children, apparently healthy, symptom-free and active, show on careful examination many deviations from fixed standards; standards of height and weight must be elastic; measures of resonance and of resilience of the chest must be rigid and estimates of acoustic phenomena must permit of a range of difference from the ideal. These facts, clinical experience establishes beyond peradventure, and they suggest a corollary, namely, that x-ray examination of the chest of such children may be expected to show comparable deviations from a fixed ideal roentgenogram.

The studies reported, fortified by past experience, warrant the following conclusions:

(1)—The data obtained on percussion and auscultation of the lungs of normal children show wide variations from a fixed standard. These variations are usual and are considered to be within normal limits.

(2)—Inasmuch as the changes refer-

red to are dependent often upon alterations that persist as the residua of past infections of the respiratory tract, it is obvious that a careful anamnesis, with avoided. Even a history carefully taken necessary if diagnostic errors are to be special reference to all infections, is often unreliable, as minimal infections are soon forgotten by many and among the unintelligent classes even more significant indispositions are not readily recalled.

(3)—Failure properly to evaluate these deviations from a fixed standard will often lead to the unwarranted diagnosis of disease and to even less justifiable treatment.

(4)—With a proper appreciation of the widest variations that the normal may present from the ideal, the informed clinician is better able correctly to understand the findings of the Roentgenologist, and each, cooperating with the other, is less liable to error.

(5)—D'Espine's sign as indicative of enlarged tracheo-bronchial lymph nodes is of little value.

(6)—Recognition of and familiarity with the foregoing data is of cardinal and practical importance to every patient, potential and established. Without a proper appreciation of the facts set forth no intelligent differentiation between a normal and an abnormal respiratory tract can be made.

In brief, to establish the presence or absence of disease, it is imperative that all data—clinical, laboratory and roentgenographic—must be evaluated and correlated and that no one fraction of the evidence be stressed to the exclusion of the others.

(Signed) C. R. Austrian
H. R. M. Landis
Kenneth D. Blackfan

May 6, 1922

REPORT OF THE X-RAY DIVISION OF
THE COMMITTEE ON MEDICAL RE-
SEARCH OF THE NATIONAL TU-
BERCULOSIS ASSOCIATION.

It is generally conceded that one of the most important factors in accurate interpretation of the appearance of morbid processes in the roentgenogram of the thorax is a thorough familiarity with the normal and variations therefrom within normal limits. With a full realization of this in view the National Tuberculosis Association in 1920 appointed

a committee comprising three roentgenologists and three internists to make a study of the normal chest of the child between the ages of six and ten years. This group was instructed to work in co-operation and to make a report of their investigations before the Association when their studies were completed and their conclusions reached. The members selected for the committee were Dr. H. Kennon Dunham of Cincinnati, Dr. Frederick H. Baetjer of Baltimore and Dr. Henry K. Pancoast of Philadelphia to act in the capacity of roentgenologists and to work in cooperation with the respective internists in the same cities, Dr. Kenneth Blackfan, Dr. Charles R. Austrian and Dr. H. R. M. Landis. Each group of two was to work independently until a satisfactory number of individuals were examined and the entire committee was then to meet and draw their conclusions for presentation. It was to be the duty of the internist in each group by careful clinical study to select as nearly normal children as possible for examination by the roentgenologist. The entire procedure was to be carried out with strict cooperation between the two members of each group.

It was soon realized by the x-ray members of the groups that an attempt to describe a normal chest was practically impossible. Their endeavors soon began to centre around the description of a theoretical normal with wide variations that would serve as a basis for the interpretation of abnormal appearances and tend to preclude the possibility of erroneous diagnosis being based upon faulty interpretations of hilum shadows, trunk shadows and linear markings more or less altered in appearance by the frequent respiratory infections of children. They realized that herein had existed the greatest source of error in interpretation, and no doubt the Association had this same thought in mind when the committee was appointed to take up these investigations. Errors in interpretation have been made chiefly in connection with the diagnosis of pulmonary tuberculosis.

It was the consensus of opinion that definite x-ray evidence in the hilum and children are probably more apt to show trunk shadows of simple as well as serious respiratory infections than adults. Practically all children of the ages of those examined have had at one time or

another one or more respiratory infections, especially measles and whooping cough, that are likely to produce very apparent changes in the shadows mentioned and which will remain distinctly visible for a variable period of time. These apparent deviations from the normal are not necessarily abnormal when observed, but may be the harmless result of one or more infections. No doubt such appearances have many times been misinterpreted as evidence of tuberculosis. In the conclusions reached by the committee the attempt has been made to preclude this possibility.

Many of the general observations made have not been included in the conclusions. One of those perhaps worth mentioning is the fact that the heart of the child is found to extend relatively further to the right than in the adult. The thoroughness with which the studies were carried out may be in part realized from the number of individuals examined. Over five hundred children were selected from all strata of life, as stated in the clinical report of the committee.

The groups comprising the committee met at the Phipps Institute, Philadelphia March 3, 1922. Prior to this meeting there were misgivings as to the possibility of an agreement upon any very definite conclusions, but much to the satisfaction of all the members a definite agreement was reached and the conclusions were completed after a few hours careful deliberation. To assist in a better understanding of the conclusions of the committee, a composite diagrammatic reproduction of several roentgenograms was made and is shown in the accompanying illustration. It must be remembered that the three zones like the chest have thickness as well as length and breadth. Thus the zones extend anteriorly and posteriorly from the lung root as well as laterally.

Conclusions of the Committee.

The Normal Chest.—The normal chest of the child from the roentgenologic standpoint is subject to such wide variations within normal limits as to be beyond the possibility of exact description.

Hilum Shadow.—The conglomerate shadow commonly called the hilum shadow, when found lying entirely within the inner third or zone of the lung area can be disregarded, (or regarded as normal) except where it is made up of

a solid mass of homogeneous shadow giving undoubted evidence that it represents a growth or mediastinal pleurisy.

Calcified Nodes.—Calcified nodes at the the root of the lung, without evidence of lung disease, are of no significance except as a possible evidence of some healed inflammatory condition, possibly but not necessarily tuberculosis. They are a common finding in normal chests.

Density and Thickness of Trunk Shadows.—In the normal lung the bronchial trunk shadows are not visible in the extreme apical regions. For convenience of description the remainder of the lung is divided into three vertical zones, extending outward from the lateral border of the spinal shadow to the lateral chest border. The inner zone contains the root shadow. The mid zone contains the trunk shadow, gradually fading out into their final subdivisions. the peripheral zone contains radiating lines from these and fading off before the periphery is reached.

Where in the mid zone or peripheral zone, these shadows do not disappear in the characteristic fashion described, the appearance may be evidence of a variety of conditions, past or present, of an inflammatory nature or otherwise. It may accompany a tuberculous process but is not necessarily indicative of tuberculosis.

Improper or Misleading Terms.—The use of the terms "peribronchial tuberculosis" and "parenchyma tuberculosis" is not to be recommended in the interpretation of roentgenograms of the chest. Until corroborated by laboratory or clinical findings the use of the terms "active" and "quiescent" should not be definitely applied to evident lesions demonstrated on plates.

(Signed) Henry K. Pancoast,
Kennon Dunham,
F. H. Baetjer.

May 6, 1922.

STATE INSTITUTION MANAGERS.

There were fifteen changes made in August in the boards of managers of the New Jersey State Institutions. Among the new members are Dr. C. H. Schlichter of Elizabeth on the Commission for the Blind. Dr. T. H. Flynn, Somerville, is continued on the Reformatory for Women board; Dr. I. E. Gluckman, Newark, on the Glen Gardner Sanatorium board; Dr. J. E. Raycroft, Princeton, on Trenton State Hospital board, and Dr. J. M. Carnochan, Princeton, on the Skillman Epileptic Village board.

LOBAR PNEUMONIA*

By Alphonse B. Dochez, M.D.,
New York City.

It is a very great pleasure for me to have the opportunity to speak here and especially to speak to you about such a very important subject as pneumonia, and particularly about that variety which is called lobar pneumonia.

In regard to the utilization of the serum itself and to the extent in which we can determine the therapeutic value of such sera. It is necessary to determine the type of organism concerned in the production of the disease and that unfortunately is one of the obstacles to the use of the serum because it is a fairly complicated bacteriological procedure. Various boards of health have taken it up so that it is now possible in many places to have that done in bacteriological laboratories and done in a short period of time. The important thing is to collect sputum as early as possible. We ask the doctors to provide themselves with a sterile dish. The patient is urged to cough up a small amount of sputum into the dish. Only a small piece is required; so that all that is necessary as a preliminary to the determination of the type of organism is to collect a small amount of sputum to be sent to bacteriological laboratories to get the type.

Now the actual technic of administration of the serum itself has gone through a considerable evolution. It was at one time considered to be very dangerous to inject it into the blood stream of human beings. For a long time it was injected subcutaneously. Considerable amounts can be put into the blood stream without danger. It is shown that in order to get protection of therapeutic efficiency from this serum it was not sufficient to give small doses of serum and large amounts had to be given and the amounts were gradually increased. We have given as high as 200 and 250 cc of serum at a single dose without bad results. It is perfectly safe to use doses of 100 cc of serum intravenously at intervals of eight hours until the symptoms abate in such a way that it seems safe to discontinue the use

*Outline of an address, giving clinical phase of the subject, before the Joint Meeting of the Rockland County and Bergen County Medical Societies in Pearl River, on May 16th, 1923.

of the serum. We observe several precautions in trying to gauge the amount of serum which we use. We dislike to use over 500 cc for a single case. As a matter of fact it is far more satisfactory to be able to carry a case through with about 399 to 400 cc of serum. However, we have used up to 1,000 and 2,000 cc in certain cases. We do not like to give above 500 or 700 cc; put 700 as the upper limit as a rule. A certain amount of judgment is required in determining the amount to give. It has been proven with all serum that it is far more valuable to be given early in the disease. We aim to give 300 cc on the first day in order to get a considerable concentration of antibodies in the blood. In many cases it may bring the temperature down and may delay the spread of the infectious process in the lung. The technique as stated for the average case is to give 100 cc intravenously every eight hours from the time it is decided to treat until the temperature reaches normal. Most cases begin to do well after about 300 cc. The temperature will come down and it will not be necessary as a rule to give a very large second dose.

As you know certain individuals are sensitive to the injection of foreign serum and react to the condition which has been termed "anaphylaxis." It is especially necessary when serum is given intravenously to protect oneself against an anaphylactic reaction. If in the course of the treatment a considerable amount of serum is given intravenously without such precaution in an individual which is sensitive, it is impossible as a rule to control it by any ordinary methods of treatment and the patient may die. In order to guard against anaphylaxis, at the same time that a specimen of sputum is collected for determination of type, one undertakes to find out whether the patient is sensitive to horse serum protein. This is done by taking a small amount of horse serum, 1-200 cc and inject it intracutaneously with suitable salt solution controls. If the patient is highly sensitive to horse serum, then fifteen minutes to half an hour a characteristic wheal appears which is a hive-like area and is surrounded by a zone of redness. If no such skin reaction appears we assume that the patient is not sensitive to horse serum. However, as an additional precaution half an hour after the skin reaction we inject one or two cc of serum subcutaneously. It has

been established by others that if an individual is highly sensitive the injection of serum will desensitize him so that it will be possible to use a full dose. Hence one or two cc injected subcutaneously to bring about a certain degree of desensitization; that is, to make the patient less sensitive. Provided there is no skin reaction and no reaction to the subcutaneous injection of the serum we proceed to give the full dose intravenously. We give the first dose intravenously very slowly so that we take about fifteen minutes to inject the first fifteen cc, watching the patient carefully all the time. If no symptoms have occurred within fifteen minutes, then it is safe to proceed with the full injection of the full amount.

We find approximately one person in 500 is sensitive and one person in 1,000 is hypersensitive to horse serum.

There is one type of reaction that occurs, the shock reaction which cannot be controlled. It consists in a chill, elevation of temperature, elevation of pulse and is more alarming. The temperature sometimes goes up a considerable degree. It is hard to guard against this reaction. It is the same type as occurs in typhoid. It can be controlled somewhat by the use of hot water bags and morphine, and by giving aromatic spirits of ammonia. We have no reason to believe that as far as horse serum is concerned, the reactions are in very great danger and they are certainly not a contra-indication to the use of serum.

There is the question of the type of case which is suitable for treatment. We are rather inclined to advise type I serum only in cases of type I infection and we do not believe in the use of a polyvalent serum containing the standard types of pneumococcus anti-body. We are rather inclined to limit the treatment of type I pneumonia. Now we believe that we can treat them at any stage of the disease. We believe of course that the most suitable type of case to treat is the case on or before the third day. It is very important to treat cases early, especially within the first three or four days. You know that as the disease progresses the infection of the lung spreads and it is unreasonable to suppose that any amount of serum or that any kind of serum is going to have any effect on such a massive infection in the chest.

The serum brings the crisis as far as the antibody content of the serum is concerned, forward. It does another thing, it sterilizes the blood. About fifty per cent. of the cases of lobar pneumonia have the organisms in the blood at one time of the disease and the presense or absence of the organisms in the blood has a very serious prognosis. We have found that a single dose of serum is usually sufficient to sterilize the blood. Blood cultures are made before each treatment and it is found that after one or two days the blood becomes sterile and remains sterile throughout the course of the disease. The serum increases the antibody content of the blood and it sterilizes the blood. The effect on the course of the disease is a little hard to show but figures tend to indicate that cases treated with serum are of somewhat shorter duration than cases not treated.

In regard to mortality statistics, it is hard to maintain satisfactory mortality statistics. The best statistics, although relatively small in number, are the statistics of the Rockefeller Institute. They have treated some 250 cases and the mortality is between nine and ten per cent. and we have been treating some cases at the Presbyterian Hospital. The statistics were collected up to 1922. From 1914 to 1921 the mortality was twenty-two per cent. in type I, which is approximately the mortality that is given for type I untreated cases. We have been treating over two years with the same serum and our mortality in some sixty cases since the beginning of 1921 is about seven and one-half per cent. so there has been a considerable improvement in the efficiency of the serum. If one takes the statistics all together, one finds that the mortality of type I pneumonia in cases treated with serum ranges about sixteen per cent. and there are certain men who claim that this a practical average mortality.

As regards the effect of the administration of serum in complications, statistics seem to indicate that the percentage is exactly the same in cases treated with serum and in those untreated. For the complications of empyema, endocarditis, meningitis, etc., the administration of serum has no value whatever. My own experience has been that the majority of fatalities in treated cases of type I infection are due to complications. We oc-

asionally see cases that are influenced by the serum even when treated on the first, second and third day but there is always a few of them that do not respond at all to the administration of serum. It is very hard to estimate the saving value of a serum of this kind without a long series of statistics and without a long series of controls.

I am asked to say one or two words about the use of vaccines in pneumonia as therapeutic agents. We do not believe that vaccines are especially valuable. Usually there are large numbers of living organisms in the lungs and in many instances the organisms are in the tissue and the injection of vaccines in such cases will not have much effect on the development of the patient's immunity. Recently a concentrated antibody solution has been made which is free from horse protein and does not produce anaphylaxis nor does it produce serum disease. It does contain a small amount of bacterial protein. It gives very severe shock reactions. It is dangerous to use in young people and in very sick individuals and in old individuals.

MEDICINAL TREATMENT OF HIGH BLOOD PRESSURE.

By Charles Greene Cumston, M. D.,
Geneva, Switzerland.

To treat high blood pressure without treating the cause will clearly result in complete failure. In point of fact, it is rather singular to regard—as some do—arterial hypertension as a kind of morbid entity when in reality it is a symptom of numerous very dissimilar pathological states, frequently having no relationship to one another. They are only related by the common fact that they end with temporary or permanent high blood pressure. Hence, it ensues—and this cannot be denied—that there is no treatment of arterial hypertension *per se*, but only treatment of those conditions giving rise to it. For example take a plethoric subject, a large eater and a heavy drinker; the plethora keeps up high blood pressure and all the usual hypotensive drugs will have no effect and are in reality contraindicated. This is an instance in which the frequent exhibition of laxatives and a reduction in the amount of food and drink will reduce the blood pressure.

King Louis XIV was in the habit of getting up in the night to eat a cold partridge and a pheasant, and during the day con-

acted himself royally at table as well. The august monarch would probably have died from the results of high blood pressure if his physicians—who were far more circum-spect than the average physician of our day—had not ordered an average of five enemata in twenty-four hours, not counting the administration of laxatives. Quite unwittingly, the physicians of Moliere's time often dealt with arterial hypertension more efficaciously than do our enlightened practitioners at present. However, we will not consider the methods in use for lowering the blood pressure in general, and shall only consider those medicaments which have proved themselves to be vasodilators. viz., the nitrites, benzyl benzoate and sodium citrate. Among the nitrites, trinitrin and sodium nitrite are most commonly employed, but it must not be forgotten that they may depress the heart. A keratin-coated pill containing sodium nitrate, five centigrams, and extract of mistletoe, seven centigrams, is useful, three to be taken daily. The nitrite is liberated in the intestine. Benzyl benzoate is given in doses of twenty drops in a 5 per cent. alcoholic solution nine times in twenty-four hours, but larger doses may be exhibited without any untoward effects. The hypotensive action of this drug is manifest. When injected into dogs a marked vasodilatation results in the domain of the splanchnic nerves, resulting in a lowering of the blood pressure. The drug may be given hypodermically in an oily solution containing two to four drops in each cubic centimetre of olive oil. Sodium citrate is prescribed in potion in doses of from three to ten grams in twenty-four hours. It must be exhibited for some time, and is more particularly indicated in plethoric subjects with hyper-viscosity of the blood.

Tincture of garlic requires great precision in its use, because it should be prepared by a maceration of equal parts of pulsed clove of garlic and water. The daily dose is from twenty to thirty drops, taken one dose, and the drug should not be exhibited for more than two to four days at a time, with an interval of five days. Prolonged exhibition results in arterial hypertension, on account of the tonic effect on the heart. But the best treatment of arterial hypertension is that which deals with the most frequent causes is arterial atheroma, with the etiological factor. One of the things as we now know that arteriosclerosis and atheroma are unquestionably the result of cholesterol deposits in the blood-vessels, it follows that the only way to deal

with this condition is to dissolve these deposits. This can be done with the alkaline phosphates, or, better still, with organic phosphatides, which dissolve the cholesterol. Their exhibition during two or three months generally lowers the blood pressure, and when this is once obtained the result is permanent, a result unattainable with the other hypotensive drugs, their action in this respect being only ephemeral.

Clinical Reports.

Case of Redception of Left Ureter and Left Pelvis:—Dr. O'Neil, in *Jour. of Urol.*, Jan. 1923, reports a case which presents a reduplication of renal pelvis and ureter on the left side. The orifices were in normal position in the bladder, one behind the other. The right side was normal.

Renal Calculi. Dr. B. S. Barringer, at a recent meeting of the N. Y. Academy of Medicine, presented a kidney containing three large calculi which had been removed from a patient giving symptoms that indicated nephrectomy as the operation of choice; two of the large stones had filled the kidney pelvis. The patient was a fat woman, forty years of age, who made an uneventful recovery from the operation.

Supernumerary Kidney.—Dr. W. R. Jamieson at the Feb. 20th meeting of the El Paso County (Texas) Medical Society, reported this case of a man who in 1919 was operated upon for a perinephritic abscess and the cavity drained, with later removal of the kidney. A urinary fistula developed and a third operation was performed, at which time the ureter was tied, on the theory that the urine was backing up from the bladder. The fistula persisted and at a fourth operation the ureter, together with a small piece of attached kidney tissue, was resected. The fistula still persisting the fifth operation was performed and a supernumerary kidney was removed from above and posterior to the normal kidney site. The operator at the original nephrectomy felt a mass in this location but thinking it the supra-renal gland, left it. The last operation was performed in January, last, and there has been no recurrence of the fistula.

An Early Case of Lues of Stomach.

By Dr. Copher, of St. Louis: Patient admitted April 28, 1921, from O. P. D., with diagnosis of lues of stomach with pyloric obstruction.

P. H.—Three miscarriages. Husband is luetic.

P. I.—Onset 16 years ago. Symptoms of distension, vomiting, and pain accentuated since August, 1920. Lost 60 pounds in weight.

Physical Examination.—No skin rash or scars. Pupils irregular. Sluggish to I. and A. Chest examination shows P. N. impaired over right upper, inconstant rales. Systolic murmur transmitted to axilla.

Abdomen. — Visible epigastric peristaltic waves. No mass. Some rigidity and tenderness on vaginal examination; shows small uterine tumor. X-ray shows a moderate grade of stenosis with motor insufficiency from a lesion involving distal pars pylorica. Wassermann 4 plus. R. B. C., 3,500,000. Hemoglobin, 75 per cent. Given salvarsan and Hgcl and K. I. Operation advised because of obstruction.

Patient transferred to surgery and operated on May 10, 1921. Tumor felt inside of pyloric lumen. No glands. Liver negative. Pylorus opened and a small tumor the size of a hazelnut found to obstruct pylorus. Pylorectomy done. Anastomosis of stomach to jejunum made according to method of Polya.

Post-operative course entirely uneventful except for an acute bronchitis which cleared up on third day. She is now receiving more anti-luetic treatment. Spirochetes have not been demonstrated in the excised tissue as yet. Microscopical examination shows a typical luetic process.

Case of Encephalitis Lethargica.

Dr. L. D. Stevenson reported this case at the Washington University Medical Society, St. Louis:

Male; white; age 37 years; admitted to Barnes Hospital April 11, 1921. First seen by Dr. G. G. Bragg on January 31, 1921. Was then suffering from naso-pharyngitis with temperature, pronounced nervous disturbance, severe pain in back of head and neck. In about 10 days temperature was about normal but pulse remained at 120, respiration 30. Symptoms of acute encephalitis developed, patient was lethargic and in muttering delirium, incontinence of urine and feces. A mild psychosis has persisted until the present, the chief features of which are disorientation in time, lethargy in daytime, restlessness with some hallucinosis at night.

On the 12th of April this patient presented the picture of a severe epidemic encephalitis with a psychosis and complete paralysis of the diaphragm on the left and partial paralysis on the right (demonstrated by fluoroscope). The temperature was not elevated but the pulse varied between 90 and 120. There was no facial palsy or other noticeable involvement of the cranial nerves. The reflexes were normal except for absence of abdominals. Tremor of face and hands noticeable. Atrophy of interossei marked in hands. The case is a severe type of epidemic encephalitis with lethargy, a psychosis and marked involvement of the cervical region of the spinal cord and illustrates the fact that the lesions in this disease can be widespread throughout the brain and at least the upper part of the cord.

Three Large Babies from One Mother.

Dr. G. B. Foscoe, Waco, Texas, reports in the Medical Record the following:

The following case is so unusual, if not unique, that it seems worthy of record.

Mrs. H. W. A., primipara, white, aged 20. On the 27th of November, 1917, I delivered her of a male child which weighed at birth 14 lb. 6 oz.

On Feb. 27, 1920, she again came under my care and was delivered of a girl weighing at birth 13 lb. 2 oz.

On Sept. 4, 1921, I again delivered the young woman. This time it was a boy who weighed 13 lb. 8 oz.

These three children were born within a period of 45 months. Their combined weight was 41 lb. The first labor was a high force delivery with a perineal laceration of the second degree. An immediate repair was made with only partial success. The other two births were normal. The three children are alive and healthy.

The mother is 5 ft. 6 in. in height and weighs about 130 lb. Her mother is a rather large woman who has given birth to six children, the largest of which weighed 10 lb. Her father also is a large man. The father of these three children is 5 ft. 7 in. tall and weighs 137 lb.

Abstracts from Medical Journals

Syphilitic Aortitis—Not all dilated aortas are the seat of a syphilitic invasion nor every aneurysm due to the Spirocheta Pallidum but it is undoubtedly true that the greatest single factor in producing an infective aortitis is syphilis. Furthermore, Turnbull found the specific aortitis was by far the most constant lesion found in syphilitics at necropsy, and Hubert concludes that aortitis comprises 50 per cent. of all visceral syphilis. Wilso Canad. M. A. J.

Primary Cancer of Lung—The malignant disease was correctly diagnosed in six of the eight cases described, all seen in 1921. The recognition of the cancer may depend on some minute bunch in the skin or scrap of cancer coughed up. The sharp pain in the side, acute, lancinating, continuing for months, spreading to the arm, was a striking symptom in most of these cases. The differential importance of this stitch in the side point de cote, has not been appreciated hitherto. The rapidly invading course of the process in the lung, without other signs of tuberculosis, testifies further to the neoplastic disease.

Eugenics Alone Eradicates Cancers.—I Frank Smithies, secretary-general of the American Congress of Internal Medicine, said at its annual meeting: "Repeated experiments have shown that imperfect tissues responsible for cancer are hereditary and that too much attention has been given to the treatment of cancer in the individual and not enough to its treatment with the race. In three generations, if the breeding of the human race could be controlled, cancer probably would disappear." He discounted the theory that cancer was essentially a hereditary disease although it had been shown to reoccur every third generation. Experiments and observations, he said, had shown the disease itself was not transmitted, but that the organic tissues of the third generation of children developed imperfections that ultimately yielded to cancerous growth.

Dr. Alfred Stengel, of Pennsylvania, described the clinical aspects of renal disease. Contrary to the belief of some, he said, food and alcohol had very little to do with causing Bright's disease.

Reflex Symptoms in Chronic Appendicitis.—Pain and tenderness in the right iliac fossa do not necessarily mean appendicitis. Constipation, nervous apprehension of appendicitis in a half-educated public, too solicitous, and deep palpation on the part of conscientious medical men, and pyelitis are common causes of these symptoms. An actually inflamed "chronic appendix" is, in fact, a rare condition, though even thickened and pus containing organs may be present for long periods and give rise to dyspepsia and colic attacks, often with slight fever. Careful examination for reflex signs during or just after these attacks may be helpful in deciding the diagnosis.—J. A. Ryle, Clin. Jour.

Testicle Transplants.—Dr. Lichenstern, in *Zeitschrift für Urologie*, Leipzig, has now a record of eighteen cases, and in all of them the implanted testicle healed in place and has apparently answered the desired purpose for years to date. In four instances he used normal testicles, and in the others undescended testicles. In eight of the cases the operation was done to cure pure homosexual impulses, and the cure was complete. This success corroborates Steinach's discovery of female elements in the sexual glands of the homosexual persons examined. In treatment of eunuchoidism, trans plantation of a testicle from the father seems the preferable technic. Muhlenham's experience with three cases confirms that the implanted testicle continues its internal secretion indefinitely. Other communications were on the relation of the prostate to the sexual function, on the chemistry of the internal secretions, and on organotherapy in gynecology, etc.

Treatment of Abortion.—Dr. Hillis, in *Surg. Gyn. and Obstet.*, reports: Two hundred cases of septic abortion were treated in two equal groups, of which one hundred were curetted and one hundred received only constitutional therapy. The latter patients showed lower mortality, fewer complications, less fever, and shorter average stay in the hospital. 122 cases of non-infected or afebrile abortions carefully studied, demonstrated that: (a) 63 per cent. occurred between the second and fourth month and 75 per cent. of these were incomplete; (b) 31 per cent. were criminally induced and therefore potentially infected, (c) 5 patients who were discharged without having been curetted, returned because of excessive hemorrhage. He concludes that patients with septic abortions should receive no local treatment till they have been afebrile for five days, except in case of severe hemorrhage. 2. Such an afebrile period converts a septic case to a non-septic one, which should then be curetted as a routine because: (a) 40 per cent. of such patients treated expectantly have to be curetted later. (b) Curettage insures an empty uterus and prevents subsequent bleeding. (c) It shortens the stay in the hospital. (d) It is relatively harmless in comparison with the good accomplished.

Carcinoma of Prostate.—Dr. H. C. Bumpas, in the *Amer. Jour. Roentgenology*, asserts that the average duration of cancer of the prostate, if untreated, is approximately three years. Roentgenograms show that metastasis

to the bone occurs in about one third of the cases of cancer of the prostate. Metastasis from atypical carcinoma of the prostate, in which the cells, because of their tendency to early metastasis, produce only slight local enlargement, may frequently be mistaken for Paget's disease. In order to treat successfully cancer of the prostate with radium it is necessary to use in the aggregate large doses (from 3,000 to 4,000 mg. hours), exposing all parts of the gland to comparatively small doses. The increased duration of life following radium treatment in cases of cancer of the prostate is in direct proportion to the amount of radium in radiation applied. No one method of application radiates all portions of the gland. The malignant gland must be radiated by urethral and rectal exposures, and by needles inserted directly into the neoplasm in order to produce complete radiation of all portions. Sacral anesthesia is a useful adjunct in the application of radium needles, making it possible to place the radium accurately and to change the position of the needles without pain; thus a more thorough radiation of the gland is accomplished.

County Medical Societies' Reports

CUMBERLAND COUNTY.

Elton S. Corson, M. D., Reporter.

The Cumberland County Medical Society repeated the former experience of several other county societies in being royally entertained at the sanatorium of Dr. Madeline Hallowell, Margate City. There are many phases of her work which is worthy of comment for our profit. Dr. Hallowell was formerly established in State institutional work, and need have no further concern as to position or income. She assumed the responsibility of the risk of establishing a private sanatorium with its many necessities. The growth of her institution necessitated enlargement. Her business ability and foresight is shown in the purchase of the fine property now occupied by her institution. The appreciation in financial value alone has amply repaid her, and the influx of pupils is already taking the present capacity of the building.

Dr. Hallowell discussed the various causes and phases of feeble-mindedness. The relation of the endocrine system, both in the mother and child, were explained. Each child is placed under the supervision of specialists, and those functions tested.

The society voted to hold its annual picnic in August.

UNION COUNTY

Russell A. Shirrefs, M. D., Reporter.

The regular quarterly meeting of the Union County Medical Society was held on the afternoon of July 11 at Bonnie Burn Sanatorium, Scotch Plains, about forty being present. Our members were greeted with a felicitious address of welcome by Dr. W. H. Murray, representing the board of managers. The usual order of business being dispensed with, an interesting tour of inspection of the grounds and buildings was conducted by Su-

perintendent Runnells, and many favorable comments were heard regarding the supervision which has made this institution a model of its kind. The essayist was Dr. J. E. Runnells, who spoke interestingly on "Some Aspects of Tuberculosis," stressing the importance of early diagnosis and recognition of the early symptoms. The paper was discussed by Drs. Crans, Murray and Vinciguerra. Applications for membership were received from Dr. J. P. Linke and Dr. W. B. Fort, both of Plainfield. A social session and refreshments concluded the program.

Miscellaneous Items

Amendment to Midwifery Act.—During the last session of the legislature of New Jersey, the midwifery act was amended to require 1,800 hours' training in a period of not less than nine months to make a candidate eligible for examination for a midwifery license.

Doctors Available at All Hours.—Eight hundred physicians of Pittsburgh, Pa., whether they are making professional calls or playing golf—will be within reach of their patients twenty-four hours a day, according to an announcement made recently by the county medical society.

The society has established the Pittsburgh Physicians' Exchange. A central telephone exchange connects with all doctors' offices who are members of the medical society. A visible file index will be kept at the exchange, and whenever a physician leaves his office, either on business or pleasure, it will be recorded at the exchange.

All patients have to do to locate their medical adviser is to call the information exchange.

New Jersey Physicians Fined.—The Bureau of Vital Statistics of the State Department of Health, during the past few months, has prosecuted successfully four physicians for failure to report births within the time specified by law. The law requires that these events be reported within five days after birth, and when a physician habitually violates this law, the case is referred to the Attorney-General for legal action. In only two of the four cases was it necessary actually to try the case as the other physicians settled by payment of the minimum penalty and costs. In all a total of \$160 was collected in fines and the costs approximated an additional half of this sum. It is anticipated that the success of the Department in securing conviction in every birth case presented will impress physicians and midwives with the necessity of complying with the law.

Chiropodists.—Dr. Robinson, replying to an article in the Critic and Guide, says the chiropodists "are all right. That they do the work they claim to do, do not degrade officially the term 'doctor,' and are much superior medically, professionally and morally to the chiropractors, who have the impudence to claim to be able to treat all diseases of the human body and mind."

Governor Silzer Appoints a Medical Advisory Board.—In extending the practice of having various non-salaried bodies of men to assist State officials in solving problems of State government and administration, Governor Silzer appointed a board of physician as a Medical Advisory Board, to conserve the health of the State and with a view toward placing technical medical knowledge at the disposal of New Jersey.

The members appointed were: Dr. Arthur L. Smith, New Brunswick, chairman; Dr. John J. Broderick, Jersey City; Dr. A. Haine Lippincott, Camden; Dr. John C. McCoy, Paterson, and Dr. Francis H. Haussling, Newark.

Although the Department of Institutions and Agencies has already such an advisory body in addition to the State Board of Control, which latter body is the legal head of the institutions' department, the Governor's action is somewhat of a new departure. The institutions' advisory board helps the Board of Control in solving administrative problems.

In making the appointments, Governor Silzer said:

"It has been found in practice that frequently State boards and departments require special information and advice from the best men available for this purpose.

"The Department of Institutions and Agencies has such a board, consisting of Colonel William A. Starrett, J. Otis Post, John H. Lippincott, Jr., A. M. Reynolds, James O. Betelle, William O. Ludlow, Walte Kidde and Leon Cubberly. Of this board Colonel Starrett is chairman. This board is frequently called in to advise the department in important matters.

"Governor Silzer has felt that such a practice might be extended. Accordingly, he recently had a consultation with members of the State Medical Society, as its recent meeting in Atlantic City, indorsed and approved a tentative plan that had been worked out by the Governor and the committee. Governor Silzer has, therefore, appointed as a Medical Advisory Board, five of the leading physicians in New Jersey, whose duty it will be to lend whatever assistance they may be able to give in matters pertaining to health policy, to the health of the State and its wards, and to disseminate such knowledge among the medical profession with the purpose of placing the technical and scientific knowledge of the profession at the disposal of the State, and of interesting the medical profession in public health problems.

"The physicians are giving their service gratuitously. It is believed that with a board of this kind co-operating with the State much will be accomplished for the State and its institutions and wards.

"The Governor is most pleased with this co-operation on behalf of the doctors of the State."

The above appointments were the result of a conference held with the Governor at the State House early in June by Drs. Eagleton Costill, English, Hunter, Banker and Muchmore, of the State Society's Welfare Committee, and the approval of the State Society of that committee's action.

THE JOURNAL

OF THE

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PUBLICATION COMMITTEE:

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Each member of the State Society is entitled to receive a copy of the JOURNAL every month. Any member failing to receive the paper will confer favor by notifying the Publication Committee of the fact.

NOTE.—The transaction of business will be expedited, and prompt attention secured if,—

All papers, news items, reports for publication and any matters of medical or scientific interest, are sent direct to THE EDITOR, New Brunswick.

All communications relating to reprints, subscriptions, changes of address, extra copies of the JOURNAL books for review, advertisements, or any matter pertaining to the business management of the JOURNAL are sent direct to THE CHAIRMAN OF THE PUBLICATION COMMITTEE, Newark.

OFFICIAL ADDRESSES.

President W. P. Eagleton is in Europe. He expects to be home after September 15th.

Dr. C. D. Bennett, chairman of the Publication Committee, has returned from his vacation trip to New Hampshire. His address is 177 Clinton Avenue, Newark.

Secretary J. Bennett Morrison is in Maine, where his address is Everett Chambers, Oak Street, Portland. He expects to be home on and after September 4th.

The Editor, Dr. D. C. English, is spending his vacation in Maine, where his address is Elms Inn, Harrison, Maine. He expects to be home on and after August 25th.

IMPORTANT NOTICE FOR EVERY MEMBER

So many errors have crept into our Official List during the past two years, it will be necessary to compile an entirely new list, going over each name and address in the telephone books and directories. This will entail an enormous amount of time and labor.

Your Secretary requests that each member will inspect the Official List for 1923, published and sent out with the June issue of the State Journal this year.

If your name and address are not correctly listed and spelled, and will please communicate with me directly, giving what corrections are necessary.

By complying with this request, you will materially aid in the compilation of this new list.

Respectfully yours,

J. Bennett Morrison, Secretary,
97 Halsey St., Newark

GIVE THIS ATTENTION AND, IF NEEDED, PROMPT ACTION.

We call special attention to the list of names on page 286, added to the Alphabetical List of members sent out with our June Journal. There never was such an imperfect list sent to our members and it is occasioning an immense amount of work to our present Secretary, Dr. Morrison. It is largely caused by our members neglecting to pay their annual dues promptly. We remind our members that the careless neglect of prompt payment of dues means to them loss of good standing in our Society and in the A. M. A.; loss of the Journal during their delinquency, loss of medical defense, if not loss of reputation for business methods and as careful practitioners of medicine. Send your dues immediately on receipt of bill and let county society treasurers send every member a bill by December 25th, and on receiving payment send the amount to the State Society Treasurer—Dr. Marsh, immediately. **Official position means official responsibility.**

We will insert in our September issue of the Journal the two Orations—Dr. Pollak's on Medicine and Dr. Gant's on Surgery; also Dr. Eagleton's Report on the Welfare Committee's work with the discussions thereon. The other Original Articles will receive insertion as early as the discussions of them are prepared and approved. We take pleasure in stating that the stenographer who served us at our annual meeting did so most acceptably.

THE DOCTOR AND HIS VACATION

In what field of endeavor other than medicine do you find men giving all their time and effort to helping others and forgetting self? Doctors should realize that in order to do their best at all times they must relax once in a while and get out of reach of the telephone. A brain beset with responsibility for the lives of others has

very little spare time to devote to the happier, lighter vein of life. When an athlete trains too hard he becomes stale and has to quit for a while, and so it is with others. It is also very easy to get in a rut, and hard to get out of it.

Everyone should so arrange their affairs that a complete change of scene from the everyday strife and turmoil will enable them to clear away the cobwebs, take a new lease on life and have the inspiration to resume work again with a rejuvenated feeling of pleasure and happiness. Our patients like to have the example of good living typified in the person of their physician. Our health is the best asset we have.—G. H. C., in the Atlantic Medical Journal.

WHAT NURSES ARE TAUGHT

One of the things that enters into the "nursing problem" is, what is she taught during her course of training? Is the teaching, especially the lectures given by the staff, in a direct line with her subsequent work? A reference to the outlines of the prescribed courses will strike one with the very evident high tone of the medical education obtained by the nurses—too high toned in fact for nurses.

A speaker at the opening of a new hospital wing, referring to the nursing staff, recently said: "They are well trained young ladies, their education is on a par with that of the medical student!" He unconsciously told a great truth. If one were to sit through a few lectures given to the nurses by the staff, the difference between them and those delivered in a medical college would hardly be noticed. All of this effort seems hardly in keeping with the end result, if it really is to be desired. Certainly a knowledge of the functional anatomy of the dorsal spino-cerebellar tract of the spinal cord is not in any way going into the making of a better nurse. Nor is a study of blood chemistry going to enhance her value as a sick-room attendant. Examples could be given on and on, as to the futility of this advanced teaching to general classes. The reading of a few answers to examination questions will enlighten anyone interested, as to just how far the words of the lecturer have penetrated.

Why continue the travesty? Why go on with the pretense of educating in medicine and surgery, when it is apparent that no such thing is being accomplished and would be doing no good if it were. If

there be any who conscientiously desire this so-called "advanced schooling" it could be had by taking part or the whole of a medical course and gotten right. If these medical college lectures were eliminated and others specifically related to nursing substituted, certainly a good deal of time in training could be cut off. At the same time more hours could be given to real practical training in the wards, operating rooms and in the special departments. With the focusing of attention on the practical course, an improvement might be observed there.

The following two questions were asked in the course on "Hospital Housekeeping" in a leading Pennsylvania hospital: The first one was: "How much paint would be required to cover a room 12x13x9 feet?" The other was: "How long should a crate of oranges last?" One somehow gets the impression here that something is missing. Even a casual observer will see that there is a great lack of common sense. There also seems to be an attempt by somebody to give the appearance of great learning. But all of this is not getting us anywhere, and it is not supplying the sick with the right kind of nurses. There will always be a demand for a limited number of higher trained nurses, but this is all out of proportion to the number required to care for the great mass of sick people.—A. J. S., in the Atlantic Medical Journal.

INFORMING THE PUBLIC IN MATTERS MEDICAL

The attitude of the medical profession and of the public towards the dissemination of medical knowledge to the laity has changed greatly in the past decade. We do not refer to the signed articles presumably paid for by newspaper syndicates and often accompanied by wood cuts of the writers—nor do we refer to the "questions and answers," such as: "Question: My hair has been falling out lately. What shall I do for it? Answer: Bathe the feet carefully morning and evening for two weeks. If not better, restate your question and enclose a stamped, addressed envelope."

Rather, we refer to the large question of presenting to the public information concerning preventive medicine and hygiene. We repeat, the attitude of the public and the profession has changed in this matter greatly of late years. However, a real problem has presented itself in the premises. It seems difficult or impossible for many of the profession to distinguish the

difference between imparting useful information concerning health matters to the public and advertising their own particular abilities. It is probably true that many times the "offending" material (speaking from an ethical standpoint) is the result of the too friendly attitude of the local editor or reporter; but whether that is true or not the "offense" frequently occurs.

The public should be given information in matters medical; and the information, to be of real value, should come from a medical practitioner, but heaven preserve us from having the subject matter introduced as it too frequently is by some such sentences as "The subject is handled in an unusually attractive and forceful way by Dr. A., who has the most extensive and thorough training along these lines of any physician in this district." We repeat—the public ought to be informed upon medical questions by medical practitioners, but in presenting this information the ethics of the profession should always be carefully guarded. If the medical profession is to save itself from everlasting disgrace something will have to be done to make it possible to present these proper subjects of information without degenerating into a form of vulgar newspaper advertising.—C. R. P., in *Atlantic Medical Journal*.

UNWISE APPROPRIATIONS.

The wisdom of Congressman Sproul's suggestion that the government shall offer a prize of \$1,000,000 to individuals for the discovery of the cure of any one of the following diseases, tuberculosis, cancer, pneumonia, epilepsy and dementia praecox, seems commendable on first thought. When we consider the hundreds of thousands of deaths, and the suffering and lowered vitality that those diseases have occasioned, and then recall the hundreds of thousands of lives that have been saved by the prevention or cure of other diseases. But on more careful consideration of the matter it seems clear that the vast amount of money could be expended far more judiciously for the eradication or prevention of the diseases named. The editor had given the matter some thought, but he finds the subject more forcibly dealt with in an editorial in the September Boston Medical and Surgical Journal, and we give a part of that instead of our own comment, as follows: "Some minds infer that the great accomplishments achieved through spending

money in some ways warrant the expectation that if sufficient money could be used almost anything would respond to the magic touch of gold. This attitude is one of the unfortunate effects on those minds that have been dazzled by exhibition of the lavish use of money. There are other features of such proposals which will arouse a feeling of indignation in the minds of most of our scientific workers, for although recognition of meritorious work and the conferring of a dignified honorarium are appreciated by all benefactors of the race, such an offer would not add one particle of energy to scientific investigation. As a rule, great discoveries in medicine have been made by persons possessed of vision and determination, actuated by altruistic motives and controlled by scientific minds. If \$1,000,000 a year could be devoted to the support of those institutions in which research is already being carried on, the investment would be more to the purpose. One may fear, on the other hand, that some impostor may prey on the credulity of the representatives of the government, as has been done, it is feared, in another country. Instead of stimulating valuable effort the exploiters of turtle serum or our later aspirant for fame, Abrams, and a host of other claimants would lay siege to the treasury, supported by affidavits and personal testimony. Any honest believer in any cure can submit evidence of his claim to impartial analysis and be sure of fair treatment. Whenever the government is ready to appropriate millions to be used by scientists there will be found many opportunities for aiding existing reputable organizations. An honest ambition to benefit the race is commendable, but all efforts along these lines should be under the guardianship of well-trained minds, endowed with capacity for correct reasoning."

VETERINARY CHIROPRACTIC.

And now the lower animals are to be "adjusted!" The house organ of a brand of chiropractic dispensed from Davenport, Iowa, prints letters from some of its "graduates" describing wonderful results attained in the "chiropractic treatment" of sick animals. One enthusiastic Georgia chiropractor relates that when he "was adjusting Henry Vinson's son for an inco-ordination causing pneu-

monia" that "Mr. Vinson says, 'Doc, I have a mule that is down in the back and can't get up and wish you would come out and see if you can do something for him.'" The versatile chiropractor, looked over his new patient and "adjusted the mule between the hip bones." The mule recovered—presumably slowly enough to allow the adjuster to escape. The same practitioner also reports that he "was called to attend Mr. Ben Vandalsem's Scotch Collie who was dragging his hind legs, and after adjusting the dog he improved and got quite normal." A Texas chiropractor records the interesting case of a "cow down, all swelled up, as if she would burst." Diagnosis: "A poisoned condition." Treatment: "I adjusted sixth and eighth dorsals and K. P. In two minutes cow was up vomiting. I came back by in one hour, cow seemingly in normal condition." Now, putting the dorsals and K. P. of a cow in position and adjusting a mule "between the hip bones" may get chiropractors into serious trouble. It is one thing to fool with the health of human beings and entirely different thing to trifle with the health of live stock. The "patent medicine" interests of the country have been powerful enough to keep off the statute books any law that would protect the public by giving it information regarding the composition of nostrums sold as home remedies. But there are some States which forbid the sale of any live stock remedy that does not bear on the label the names of its active ingredients. Hence it may easily come to pass that if the chiropractors attempt to treat cows and pigs they may find themselves in hot water. That men, ignorant of the body and its processes, should treat the ailments of men, women and children is apparently a small thing; human life is the only thing involved. But that ignoramuses should trifle with the health of a horse or a hog is an outrage; that is property. If chiropractors are wise they will confine their malpractice to humans; it is safer.—A. M. A. J.

PITILESS PUBLICITY IS THE CULT-KILLING CORROSIVE,

The Illinois State Medical Society Contemplates a Campaign of Education of the Public.

The menace of the quack and the despoilation of the doctor will receive a lethal knock-out blow from the lay-edu-

cation publicity campaign now under consideration and that probably will be undertaken by the Illinois State Medical Society. Every physician and surgeon in the state is asked to co-operate and is needed in the campaign. Medicine has sat silent for too long. Through glaring spectacular statements, and bought and paid-for space in newspapers and periodicals, the charlatans have distorted medical facts and are menacing the health welfare of the people by playing on the credulity of the unsophisticated.

So brisk is trade in the cults, that even blacksmiths, carpenters, plumbers and dressmakers are being recruited to take easy courses of from three to six months' duration and hang out shingles as healers.

At the State meeting of the Illinois State Medical Society it was voted to fight the quacks with their own medicine. The matter was taken up by the council of the Society at its September meeting and a committee was appointed to devise ways and means to educate the public to the dangers of medical practice by the untrained and uneducated. The committee was instructed to prepare and supervise matter that is to be printed in the daily newspapers and periodicals that will open the eyes of the public as to the progress in medical science, what medicine has done and is doing for humanity, which is intended to specifically impress upon the people at large, that a sick man needs a doctor and not a mountebank. Articles for the lay press will be handled by reliable organizations, familiar with the best methods of securing results from publicity propaganda.

Educational data will be placed before the public, largely through the lay press, assisted by lectures, pamphlets, etc. The subject-matter for the press, pamphlets and the themes for the addresses to be made in public places will be educative, elucidative and general. Exploitation of any one individual or paternalistic theory or groups working at propaganda purposes will be disbarred. This campaign will be along lines showing the virtues of the real in contrast to the dangers of the bogus. It will open the eyes of the men who are too ignorant to distinguish medical skill from bunkum, and clear away the fogs from those who should know better but who do not—turned in the wrong direction perhaps, by some careless physician who is prone to de-

spise the "Day of small things" and laughed away the seeming trivial pain that a patient complained of, because only an appendectomy or a cancer of one of the important organs, was of moment enough for consideration.

The newspapers of the present day are without doubt the greatest educative mediums. When the campaign is launched, it is through these that the committee will work with interesting editorial articles and descriptive stories, enlightening the public as to the truth and principles contained in these developments, progress and necessities of medicine and surgery, and its application to human well being.

The United States Government has found it expedient to advertise government securities in this day of get-rich schemes. Purveyors of natural resources, such as leather, wool, butter and eggs, are advertising daily the difference of their products over the synthetic wares flooding the markets.

Medicine must retain her traditional dignity, but when the health welfare of the people is jeopardized, she must arise and expose the invaders.

A campaign of the sort alluded to cannot be prosecuted without funds. The treasury of the state society is without the needed money, the campaign, therefore, if carried on at all, must be supported by popular subscription. It is, therefore, hoped that when the doctors of the state are solicited to subscribe for this worthy cause, every doctor will respond cheerfully. Serious diseases diverted from the incompetent will result in the saving of thousands of lives and will prevent much permanent invalidism.

Pitiless publicity is the cult-killing corrosive!

Practical ethical publicity is the redemption of the profession.

For the sake of humanity, let this campaign flourish!

"EAT-MORE" CAMPAIGNS.

This is the day of the "Eat-More" campaign. From billboards, newspaper advertisements and periodical pages, the slogan "Eat-More" crashes upon the reader's intelligence. He is besought to eat more meat; he is requested to eat more raisins; it is hoped that he will eat more oranges; he is invited to eat more apples; the coffee planters beg him to drink more coffee; the tea importers be-

sech him to imbibe more tea, and the tobacco manufacturers plead for purchase in carton rather than in individual package. And whenever possible the earnest advertiser drags in a medical argument to sustain his plea. Without reference to the actual justice or injustice of any of this advertising, it is well to bear in mind that greatest of all medical aphorisms: "Moderation in all things."—A. M. A. J.

SCARLET FEVER CONTROL.

From N. Y. Tribune, July 24.

Such a medical achievement as the control of diabetes by means of insulin makes plausible the reports of success in dealing with other maladies. Two Italian physicians believe they have discovered the scarlet fever bacillus and that they have found a serum which is effective. If they have really done so one of the most baffling and insidious of diseases may be warded off as surely as, for example, typhoid. Before accepting the fact as accomplished it is well to remember that discoveries of the scarlatina germ have been reported now and again during the last twenty years and the results have been disappointing. In Stockholm, in London, in Boston bacteriologists from time to time have announced very hopeful experiments with vaccines, and all thought they had isolated the guilty bacillus as confidently as do the Italian experts. But the quest still goes on.

Scarlet fever is a visitor dreaded in all households. There is mystery in its cause and its contagion. The mortality of the disease is high, its complications are severe and bad after effects are likely to be persistent. Formerly scarlet fever was supposed to be communicated chiefly in the period of desquamation, or "peeling," but in the modern theory it is transmitted in the earlier stages. Quarantine and fumigation used to be the rule. The most drastic old precautions are now regarded as extreme. In answer to a complaint last year that a nurse in Flushing did not change her dress before entering the sickroom, Dr. Copeland, then Health Commissioner, replied that the nurse was acting according to the present-day practice. At the same time, Dr. Copeland observed that public agitation of methods of contagious disease control was not helpful. Perhaps he was right. The public must trust to the best medical opinion of the day, though realizing that the physicians themselves do not yet know everything with certainty about a plague so treacherous as scarlet fever. An effective vaccine against this disease will be a lasting benefaction.

Aint Osteopathy Wonderful?

South Bend (Ind.) Tribune.

All of this was demonstrated to 2,000 men and women at the Waldorf Hotel at the opening of the twenty-seventh annual convention of the American Osteopathic Association by Dr. C. P. McConnell of Chicago.

Dr. McConnell's argument ran about as follows:

"Red blood is manufactured in the marrow of the bones.

"The ribs contain more marrow than any bones in the body except the spinal column. Maladjusted ribs, or total loss of a rib, results in a disruption of the flow of nutriment. Hence a decided diminution in the number of red corpuscles.

"The normal blood count is 5,000,000. A patient came to me with a decided maladjustment of the ribs. His count was just 2,000,000. By proper manipulation, tilting and exercises that restored the abdominal organs to their proper place, the patient's blood count was increased 1,500,000 within a week. This may be entitled doming the diaphragm."

NAMES OF MEMBERS OF THE MEDICAL SOCIETY OF NEW JERSEY, OMMITED IN THE OFFICIAL LIST.

The following names, erroneously omitted from the Official List of the Medical Society of New Jersey, and those subsequently reinstated, have been sent to the American Medical Association at Chicago. For addition to their list:

Allen, Jas. Stockdall, 41 Main st., Orange.
 Behrens, Herman, 313 Webster av., Jer. City.
 Bailey, Fred R., 1165 Jersey st., Elizabeth.
 Bardsley, Chester A., Laurel Springs.
 Blakley, E. W., 1 Ivy Court, Orange.
 Busby, Franklin B., 429 Casper st., Camden.
 Butler, Samuel S., 1100 Kaighn av., Camden.
 Bingham, Samuel S., 125 Harrison st., E. Or.
 Brim, Anne J. S., 549 Clinton av., Newark.
 Boyer, Charles G., Armandale.
 Coleman, Austin H., Clinton.
 Carnan, John H., 602 Crescent av., Plainfield.
 Callery, William T., 43 Columbus ter., Weeh.
 Conoly, Lacy N., 412 Broadway, Camden.
 Casale, John Baptist, 98 Bl'mfield av., N'wark
 Charbonneau, Eug. G., 29 Pen'gt'n st., N'wark
 Cohn, Herman, 393 Clinton av., Newark.
 Decker, Frederick H., Frenchtown.
 De Merritt, Chas. L., Term. Bldg, Hoboken.
 Dorn, Elliot I., 143 Weequahic av., Newark.
 Ewen, Warren L., Salem.
 Flynn, Edward A., 151 Wash. av., Newark.
 Glasser, Emanuel, Marshall st., Elizabeth.
 Gary, Arthur D., Ringoro.
 Gardam, J. W., 395 So. 15th st., Newark.
 Gershenfeld, David B., 255 Clinton av., N'wark
 Holland, Ruben T., 887 St. Geo. st., Roselle.
 Holtzman, Michael, 167 Second st., Elizabeth.
 Hellstron, E. C., Hudson Pl., Hudson Heights
 Hallinger, Earl S., Hadden Heights.
 Huberman, John, 141 W. Kinney st., Newark.
 Jackson, E. C., 98 Washington st., Newark.
 Kalter, George, 640 Prospect st., Maplewood.
 Lindley, Chas. D., Los Angeles, California.
 Klugman, Lewis T., 75 Ave. C, Bayonne.
 Long, Miles T., 226 Monticello av., Jer. City.
 Lyon, Leslie C., Magnolia.
 MacMillan, Wright, 99 Gregory av., Passaic.
 Mazzarella, Carlo, 56 Czon st., Paterson.
 MacArthur, C., 172 Roseville av., Newark.
 Meeker, Irving A., 581 Valley rd., Up. Mont.
 Moore, Wm. G., 1576 Mt. Ephraim st., Camden
 Nemser, Rudolph W., Jamesburg.
 Nash, Wm., G., 239 Springfield av., Newark.
 Nalit, David I., 28 W. 33 st., Bayonne.
 Nevin, John, 20 Baldwin av., Jersey City.
 Neves, Chas. S., 1206 Bloomfield av., Hoboken
 Nydes, John, 239 Springfield av., Newark.
 Pyle, Immanuel, 56 Monticello av., Jer. City.

Pelusio, August N., 125 E. 16 st., Paterson.
 Rothenberg, Samuel, 54 16 av., Newark.
 Runyon, Mefford, 110 Irvington av., So. Or.
 Roberts, Harvey H., Ritz Carlton Hotel, A. C.
 Rufe, John J., High Bridge.
 Schiffman, Samuel C., 407 Avon av., Newark.
 Schaffler, Wm. G., 29 Morgan pl., Princeton.
 Schwartz, W. A., 344 Seventh st., Jer. City.
 Schurter, Maximillian A., Burlington.
 Schikson, J. J., 838 So. 12 st., Newark.
 Wainwright, John M. B., 256 Mont. st., J. City
 White, Hugh M., 901 Summit av., Jersey City.
 Williamson, William L., 22 22nd st., Bayonne.
 Weiner, Samuel E., 904 Pacific av., Atl. City.
 Wolfe, J. C., 15 Gates av., Montclair.
 Wyatt, Hugh M., 135 Clinton av., Newark.
 Yaguda, Asher, Beth Israel Hosp., Newark.

The following names though printed in our Official List were, by some clerical error, omitted from the American Medical Association List. They were forwarded again for insertion:

Robinson, Moe, 1014 E. Grand st., Elizabeth.
 Rose, Abraham, 12 Third st., Elizabeth.
 Savoye, Richard G., 115 Central av., Westville
 Schlicter, Chas. H., 556 N. Broad st., Elizabeth
 Sell, Frederick W., 166 Irving st., Rahway.
 Shangle, Milt A., 34 Prince st., Elizabeth.
 Sinclair, Robt. W., 178 Elm st., Westfield.
 Sisserson, W. Wilson, Westfield.
 Stein, Emil, 151 Second st., Elizabeth.
 Stein, Isadore, 201 Elizabeth av., Elizabeth.
 Stein, Martin H., 163 Second st., Elizabeth.
 Stern, Arthur, 224 E. Jersey st., Elizabeth.
 Strickland, G. W., 517 N. Broad st., Elizabeth
 Tator, Arthur E., Summit.
 Tidaback, John D., Summit.
 Tilton, William R., 146 Madison av., Elizabeth
 Turner, William F., 519 Magie st., Elizabeth.
 Upham, Chas. E. H., 302 Westville av., Eliz.
 Vail, Jas. Lindley, Cranford.
 Van Horn, Alfred F., 514 Central av., P'nfield
 Vinciguerra, Michael, Elizabeth.
 Vogel, H. Austin, Eliz. Gen. Hosp., Elizabeth.
 Wade, Simeon F., 555 Newark av., Elizabeth
 Wagner, Otto, 1051 Elizabeth av., Elizabeth.
 Walsh, Thomas J., 171 Stiles st., Elizabeth.
 Warncke, Frank H., 117 Stiles st., Elizabeth.
 Yood, Raphael, Plainfield.
 Young, John S., 70 Irving st., Rahway.

Medical Society Aims to Standardize Disability.—At the annual session, Atlantic City, June 23, the Medical Society of New Jersey authorized the appointment of a committee to work out a basis for standardizing injuries which come under the workmen's compensation act of New Jersey. Dr. Wells P. Eagleton, Newark, president, it is said, will appoint as chairman of the committee Dr. Elbert S. Sherman, Newark. After an exhaustive study, a schedule will be arranged that aims to fix the percentage of disability resulting from any injury covered by industrial insurance, and thus eliminate the difference of opinion that usually prevails in settling compensation problems.

Dispensaries and Clinics.—According to the A. M. A. Jour. the total number of dispensaries in the United States is 3,294. Of these 935 are general dispensaries and the following special dispensaries: Tuberculosis, 667; venereal dis-

eases, 487; nervous and mental, 260; baby and child clinic, 566; out-patient department of eye, ear, nose and throat hospitals, 37; out-patient, U. S. Public Health Service, 139; out-patient of orthopaedic hospitals, 16; miscellaneous, 53. Besides these there are special clinics of general dispensaries: Tuberculosis, 221; venereal, 344 and nervous and mental, 85. Total of all 3,944. The total number of individual patients in all within a year is approximately 8,000,000.

War on Japanese Beetles.—While the Federal Government and New Jersey and Pennsylvania have been appropriating more than a million and a half dollars to find a means of extinguishing the pesky insect, which has been responsible for enormous crop losses, its natural enemy has been flying around unnoticed. This remarkable discovery was made Sunday by William R. Capewell of Moorestown, and verified recently by Dr. H. R. Skinner, entomologist of the Philadelphia Academy of Natural Science. Skinner was cleaning his yard when he noticed a large grey insect carrying a green beetle in his claws. Looking at the queer funeral march, Capewell discovered that the smaller bug was a Japanese beetle and its conqueror a bug of a species he had never seen before.

Capewell told the incident to Dr. Alexander MacAllister in a visit to the physician's office at 582 Federal street, and the latter asked him to bring a sample of the beetle's enemy to him. The Moorestown man procured two Japanese beetles and one of the larger bugs, put them in a glass bottle and brought them to Camden. Before he reached the city, the "Assassin Bug," for that is its common name, had killed one of the smaller bugs. In the office of Dr. Skinner, to whom Dr. MacAllister took the miniature fight exhibit, the two watched the "Assassin Bug" dispose of the second victim.

Dr. Skinner was highly interested in the discovery and declared that, in his opinion, Capewell's accidental find might be the first step in the extermination of the pest. The entomologist intends to send a sample of the bug to Washington immediately. If the bug is found to be a solution of the troublesome problem of the beetle, much credit will be due the two South Jersey men; Capewell for his discovery and Dr. MacAllister for his prompt action in calling it to the attention of authorities.

Insulin Demonstration at Morristown.—A clinic on the treatment of diabetes in children with insulin, attended by physicians from all sections of the country, was given at the Physiatrix Institute, near here recently by Drs. Frederick M. Allen and James Sherill. They showed twenty cases of the disease at various stages under treatment in the institute. Some of the children have had diabetes six years and been under treatment at the institute by diet regulations, receiving insulin since last August. Some have gained as much as thirty pounds, but the physicians advise against gaining weight too rapidly. Dr. Sherill says they do not think insulin is a cure and all the institute's patients so understand it. It is only a treatment and all patients do not need insulin, particularly in the early stages of the disease,

if they follow the proper diet. The use of insulin has proven of most value in cases where there is loss of weight and strength and the patient is unable to work. There are between twenty and thirty members of the medical profession at the institute studying the treatment of this disease, some of them from England, Australia and Canada, as well as many parts of the United States.

INSULIN OR ILETIN

The increasing number of reports of the use of iletin gives rise to a strong suspicion that iletin is being administered in cases that would be better off without it. Any case of diabetes that can be rendered sugar-free and acid-free and brought up to a maintenance diet sufficient for the enjoyment of life and the pursuance of an occupation, by the application of the Allen method or modification of Joslin or Wood-yatt should not be given iletin except in an emergency. Such an emergency might be the necessity of a surgical operation or the sudden interference with carbohydrate tolerance, threatening acidosis and coma, as a result of an acute infection or other cause. The indications for iletin, as at present recognized, are as follows: (a) Diabetes in children who cannot be properly nourished without it; (b) cases of diabetes coma; (c) cases in which the carbohydrate tolerance cannot be brought up high enough by simple dietic treatment to make individual physiologically efficient. Iletin is an epoch-making addition to our methodical armamentarium, but it should not be abused and it does not obviate a thorough practical knowledge of dietetics and the physiology of metabolism on the part of the physician who undertakes the treatment of diabetes cases.—L. L. in *Atlantic Med. Jour.*

Hospitals; Sanatorium.

Insulin in Newark Hospital.—Insulin has been used successfully since April in the Newark City Hospital on approximately thirty-five patients, according to Dr. Earl H. Snavelly, superintendent of the hospital. In every case, Dr. Snavelly said improvement of the patient's condition has been immediate and has continued until he was well enough to be discharged, if there were no other disease condition for the insulin to cope with.

St. Mary's Hospital, Orange.—The Newark Evening News of July 26 gives three excellent cuts of the Metcalf Foundation Apparatus for Cancer Treatment as follows: No. 1, Operator's control room for use of deep ray therapy equipment at St. Mary's Hospital, which is declared to be the most efficient in the world; 2, Treatment room; 3, Machine room, showing three transformers and rectifier, capable of delivering 300,000 volts.

The Rahway Hospital has received from the United States Metals Refining Company, of Chrome, through Dr. J. M. Randolph, a set of bone-setting instruments.

Bonnie Burn Sanatorium.—Dr. John E. Runnels, sends the following report—On May 31st there were 244 patients in the sanatorium,

141 males and 103 females. This included 78 children in the preventorium. Since the last report 34 patients have been admitted, 17 males and 17 females. Seven of these admissions went to the preventorium. Among these admissions were 6 re admissions. The admissions are classified as follow: Pretubercular, 8; incipient, 2; moderately advanced, 8; far advanced, 15. Present June 29th, '24.

Deaths.

BRAY.—In Cooper Hospital, Camden, N. J., June 9, 1923, Dr. Walter S. Bray, of that city, aged sixty years.

CONOVER.—At Elmer, N. J., June 19th, 1923, Dr. James V. Conover of that city.

DOUGHERTY.—At Greenwood Lake, July 21, 1923, Dr. Arthur Cole Dougherty, aged 64 years.

Dr. A. C. Dougherty died at Greenwood Lake, where he had gone for his health about a month ago. He had suffered a stroke of apoplexy three years ago and his health had been failing since.

For a time Dr. Dougherty was a member of the staff of the City Hospital, and he was also surgical clinical assistant at St. Michael's Hospital. He was a member of the Essex District Medical Society.

He was a member of the American Medical Association, Academy of Medicine of Northern New Jersey, and an honorary member of the Practitioners' Club of Newark. He was for a long time surgeon of the Essex Troop.

Dr. Dougherty was born in Newark December 10, 1858. He attended Princeton for one year and was graduated from the College of Physicians and Surgeons of New York with the class of 1882.

His medical studies were also pursued in the office and under the direction of his father, Dr. Alexander H. Dougherty, who practiced in Newark.

Public Health Items.

Foreign Health Officers to Visit Here.—A mission comprising public health officials from twenty-one different countries will soon visit the United States to study public health administration in this country. It will be under the auspices of the League of Nations' health committee. Similar missions have already visited England, Austria, Italy and Belgium, it is reported.

Newark Health Report.—There were 422 deaths in Newark during May, being a death rate of 11.5 per 1,000 population. The principal causes of death were: Tuberculosis, 37 cases; cancer, 25; apoplexy, 28; pneumonia, 33; organic heart disease, 73; Bright's disease, 28; congenital debility and malformation, 37. There were 933 births during the month.

Newark Health Report for 1922.—There were twice as many births as deaths in New-

ark in 1922, but the birth rate for the city was less than in 1921, and the death rate higher. Infant mortality also was heavier. The total number of births last year was 11,001, and of deaths 5,058, the rates being 25.5 births per 1,000 inhabitants and 11.7 deaths. For the preceding year, the birth rate was 27.5 and the death rate 10.9.

Campaign Against Rabies.—The board of health of Bayonne made an emergency appropriation of \$1,000, June 12, with which to combat the stray dog nuisance in the city. Dr. William W. Brooke, health officer, is making an effort to have all the dogs in the city vaccinated. Fourteen persons have been bitten by dogs and cats recently. Eleven of the dogs were found to have rabies and the eleven persons bitten by them are under treatment. The cost to the city of each case will be \$40.

Undergraduate Training in Tuberculosis and Public Health Work.—Physicians will greatly appreciate the opportunity which many of the present undergraduate men are having to acquire more training in tuberculosis work and in public health matters generally than was their lot in former years. In 1916 the National Tuberculosis Association endorsed the idea of having tuberculosis wards in general hospitals while at the Atlanta, Ga., meeting of the National Nursing Associations and at the Boston meeting of the American Medical Association the project of having pavilions for tuberculous in connection with general hospitals was approved. This means greater efficiency in the training of both physicians and nurses in work for the tuberculos. So much is the national association impressed by this need that it is giving special attention to work with medical colleges, aiding them to develop their undergraduate tuberculosis training.—A. J. Strawson: Nation's Health, March, 1923.

First Aid Car.—The American Red Cross is about to put in service a Pullman car reconditioned and equipped to be used in demonstrating first-aid work. A lecture room will accommodate an audience of fifty persons, and is so arranged that it can be quickly transformed into an emergency hospital with a capacity of thirty patients. It will carry a large supply of first-aid equipment and hospital supplies and surplus food. Two competent surgeons and their assistants will constitute the staff. The car will co-operate with Red Cross chapters in the various towns and cities in an effort to promote and organize first-aid classes in Y. M. C. A. and boy scout organizations, and in schools and colleges. The first trip will be over the Baltimore & Ohio system.

The Red Cross took up First-Aid work in 1899, and in the railroad campaign covered during the succeeding six years extended its service over 206,000 miles of railroad, gave 7,000 lectures and demonstrations, reaching over one million people. From 1910 to 1922, 164,121 persons took and completed a course of ten lessons, and received a Red Cross First-Aid certificate.

The instructions given has added tremendously to efficiency in dealing with accidents before the arrival of a doctor, and has often provided skillful assistants to physicians.—Boston Med. Jour.

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ORATION IN MEDICINE

Delivered at the 157th Annual Meeting of the
Medical Society of New Jersey at
Atlantic City, June 22, 1923.

By Berthold S. Pollak, M.D., F.A.C.P.,

Medical Director, Hudson County Tuberculosis Hospital and Sanatorium; Phthisiologist, Jersey City Hospital; Consultant Phthisiologist, Christ Hospital, Jersey City, and St. Mary's Hospital, Hoboken; President, New Jersey Tuberculosis League.

Jersey City, N. J.

Retrospective observation, concerning the progress of medicine indicate the possibilities, which may act as a guide and an inspiration for its future development. A perusal of the history of medicine in that period is responsible for our attempt to draw from it essentials to govern and direct us in submitting for your consideration the ideals, which actuate us in responding to the invitation of the Scientific Committee of the State Society and accepting the great honor conferred upon us, by being privileged to deliver the Oration in Medicine.

Thus, it is most natural, when, in quest of a topic, which would adequately dignify the honorable assignment of the Oration in Medicine, that we turn again to the same seers of more or less modern medicine for inspiration, instruction and advice. The giants of the time, immediately preceding us, rise before our mental vision. We walk again with Agnew, Wood, Pepper, Holmes, Weir, Mitchell, Osler and their contemporaries and again delight to be privileged to be in their atmosphere. We again experience the personal contact between teacher and pupil, which was so largely responsible in shaping our life's work and in directing our professional future; from their lives we attempt to draw the lesson of the hour. In this meditative mood we feel ourselves called upon to react to these influences and accept, with

avidity, the opportunity thus offered. "Opportunity and Responsibility are twin sisters and are inseparable," says Finney; thus a responsibility is offered to me by the opportunity to deliver the Oration in Medicine. The inspiration of the moment is to couple a few dominant thoughts and, by citation of precept and example of leaders within our memory, emphasize those things which made *them* strong men, *leaders* in medicine, *men of affairs*, *men of heart*, whose *lives* we delight in emulating. The lesson of the hour, indeed, stresses the necessity of the humanities in medicine, for, though we may possess the *science* of a *Harvey* and the *art* of a *Sydenham*, yet there may be lacking in us those *finer qualities of heart and head*, which count so much.

The fully-equipped physician must know *more* than disease and drugs; he must know *human urges*, fundamental and acquired, and their dominion over men. The lives of really great physicians, from Hippocrates to Osler, testify to this. Only too true, is Mathew Arnold's oft-quoted statement, to the effect that two-thirds of human life has to do with problems of conduct; so, in medicine, we might agree with Danna, when he says that Arnold's statement is even more true in medical practice, that two-thirds of efficiency and success depend upon conduct and character and only one-third upon technique.

Studying the peaks, in the history of medicine, we find that they have been coincident with, if not actually an outgrowth from, a great epoch in the cultivation of the humanities. Likewise, the individual lives of the most eminent physicians have been superstructures of science, built upon foundations of personal culture. We would emphasize, under the term of "Culture," the study, knowledge and sympathetic appreciation of the best things, thought, said and done, in the history of

mankind. Cultivation of the aesthetic sense, is of practical value to the physician, for we all realize that doctors who have a sincere religious feeling and interest, who have some music or art, as an avocation, who believe and *practice* social service, penetrate more easily into the souls and hearts of their patients. To the absence of such culture, to the over-emphasis upon technique and the neglect of education, in the broadest sense, are chargeable the lack of mental balance and sanity, the epidemic of fads, foibles and "isms," which are bearing upon medicine, on all sides, today. The vulnerable spot of the *scientist*, is the point of attack for the *pseudo-scientist and the quack*. What answer has technique to the great human cry that is being momentarily drugged into silence by one after another of the fads of the day? Naturally, people snatch at the panacea, particularly when it is offered under the stamp and seal of the medical profession. Perhaps the art of medicine cannot be taught, but the *fundamental principles* upon which it is based can be formulated and stated. He, who assays to acquire the art, can then decide whether it is beyond his accomplishment or not. At least, he should have the *opportunity*, and he should be constantly reminded that such acquisition is essential to his success. By the neglect of the studies of the humanities we lose precious opportunities, for, "A man does not live by his bread alone." We cannot follow our busy profession without getting into a rut. No physician, whether his clientele be among the aesthetic, the rich, the affluent or the very poor, can afford to have learning only. *Culture* is the keynote of our success. *No one*, and particularly the practitioner of medicine, can afford to destroy its refining influence. Previous conditions and environment may be great obstacles in our task, which can only be realized after years of not too conscious an effort. Our companions, our books, our ambitions and aspirations must lead us to appreciate that we need clear heads and kind hearts. Our work is arduous and complex, requiring the exercise of the very highest faculties of the mind, while constantly appealing to the emotions and finer feelings. Our profession, then, must be one whose men are actuated everywhere by a desire to devote their efforts and their talents to the relief of suffering humanity. *Such* were the men, typified by the teachers of a decade or two ago, and *such are* the men we meet daily, when in contact with our professional brethren; men who are willing

to sacrifice and often *have* sacrificed their own lives for those of their Fellowmen; men who, unconsciously perhaps, and to a different degree, are following in the footsteps of saints and seers of biblical history. Are our ideals too high? We rather think not. In our hospitals and clinics we see, daily, the joy and happiness that come to those who minister to the unfortunate, regardless of pecuniary returns. Their names are legion. You all must have read the autobiography of the pioneer of the Adirondacks, E. L. Trudeau, a sufferer, himself, from the great "White Plague," who said: "To look about me on those I have helped, in the hour of need and to feel their daily gratitude and love, is a joyful heritage, indeed, which endures in the world when all else passes away; which brings some contentment and peace in hours of physical misery and discouragement."

Robert Louis Stevenson, who, likewise, was a victim of tuberculosis, wrote about the physician, as follows: "There are men and classes of men, who stand above the common herd, the soldier, the sailor, the shepherd, not infrequently; the artist, rarely; the physician, almost as a rule. He is the flower of our civilization and, when the stage of man is done and only to be marveled at, in history, he will be thought to have shared as little as any in the defects of the period and most nobly exhibited virtues of the race. Generosity he has, such as is possible to those that practice an art, never, to those who drive a trade. Discretion, tested by a hundred secrets; tact, tried in a thousand embarrassments, and, what are more important, Herculean cheerfulness and courage." Such is the opinion of this great student of humanity. May not the eloquent words of Bartlett be cited here, to dispel any doubts created within the mind of anyone with pessimistic tendencies, as he uttered the words to sooth the heartache:

"There is no process which can reckon up the amount of good which the science and art of medicine have conferred upon the human race; there is no moral calculus that can grasp and comprehend the sum of their beneficent operations. Ever since the first dawn of civilization and learning, through 'The dark, backward and abysm of time,' they have been the true and constant friends of the suffering sons and daughters of men. Through their ministers and disciples, they have cheered the desponding, they have lightened the load of human sorrow, they have dispelled or

diminished the gloom of the sick chamber, they have plucked from the pillow of pain its thorns and made the hard couch soft with the poppies of delicious rest, they have let in the light of joy upon dark and desolate dwellings, they have rekindled the lamps of hope in the bosom of despair, they have called back the radiance of the lustreless eye and the bloom of the fading cheek, they have sent new vigor through the failing limbs, and finally, when exhausted in all their other resources, and baffled in their skill—hand-maids of philosophy and religion—they have blunted the arrows of death and rendered less rugged and precipitous the inevitable pathway to the tomb. In the circle of human duties I do not know of any, short of heroic and perilous daring, or religious martyrdom and self-sacrifice, higher and nobler than those of the physician. His daily round of labor is crowded with beneficence, and his nightly sleep is broken, that others may have better rest. His whole life is a blessed ministry of consolation and hope."

Culture and service to our fellowmen form the superstructure upon which the whole of a successful professional life is built, like a fortress. Yet Hare, in a recent address before the International Congress of Medicine and the American College of Physicians, using the term "The dangers of the hour," points to some prevailing practices which, if continued, are bound to undermine our influence for good. We refer particularly to the practice of a few, charging excessive fees for their services, thus making the benefit of their knowledge and learning limited to a few, to the disadvantage of the many. We deprecate, with him, the growing tendency to specialism, at the expense and sometimes to the ridicule of general medicine. We believe, with the students of the present era, that the time will never come when the influence, the learning, the broad concept and the broader vision of the general practitioner will be supplanted. We believe it was McKenzie, who designated the general practitioner as the real diagnostician of the time. Our experience is in perfect accord with the expressions heard on all sides, that the supposed renaissance, due to the perfection and equipment of the modern laboratory and its instruments of precision, is really at hand. We would continue to prefer to accept the teachings of Laenec and his simple instrument, the stethoscope, and accept, through sound, clinical reasoning, a diagnosis thus arrived at, instead of having the soulless laboratory

interpret for us. All of us, in the special fields and in general practice, must realize that too much emphasis is placed upon artificial means and their deductions. The dictum of the laboratory and the interpretation of the x-ray, only too frequently, are depended upon and resorted to, to arrive at a diagnosis of pulmonary tuberculosis; for instance, when the very earliest stages of such disease might have been more readily understood, had the observations and teachings of Laenec been put into practice. Yes, the laboratory is an important adjunct, but, after all, experimentation is largely tried on the animal. Is its cellular construction, its nervous mechanism, its glandular secretion like that of the human, and, if not, are the evidence and the knowledge thus secured potential factors in solving problems, or are they not mere links in a chain?

We do not attempt to detract from those whose studious efforts have made possible this advance, but we are pleading for a wider application of the studies which the masters of a decade or two before us taught that are now being relegated for untried measures, that have not stood the test of time.

Another spirit that has manifested itself in the profession recently and which is not worthy of us, one that needs to be discussed, so that it may be expurgated, is the spirit of intolerance, of narrowness. "Breathes there a man, with soul so dead" that it does not glow with the thought of what men of his blood have done and suffered to make his country what it is? There is room, plenty of room, for proper pride of land and birth. What we protest against is a spirit of intolerance that makes the mental attitude so bitterly antagonistic to everything foreign, that subordinates the race to the nation, forgetting our ideals, based upon human brotherhood. Let us forget past differences, let us remember that medical science has no geographical boundaries. It is with sincere regret that the speaker, at a recent International Congress on Tuberculosis, held in London in the Summer of 1921, was obliged to witness the exclusion of the German delegate, and, greater still, was his chagrin, when, again, in Brussels, in the Summer of 1922, in spite of his, and other protestations, Germany was once more denied the opportunity of asserting the right that a common spirit of professional fraternalism should have granted her representative. Even now their status has not been fixed, and probably not until 1924, when we meet

in Bern, will they deign to admit them. What a pity! What a narrow vision! Have we forgotten the immortal Koch, who furnished the alpha and omega, the cause and the effect of the whole tuberculosis problem, the tubercle bacillus? Have we forgotten how we sat at the feet of this master? Now, Fellows of American Medicine, we must follow in the footsteps of the men of vision and adopt broader and humane policies for our own government and our own mutual advancement and for the advancement of humanity. We have enjoyed a peculiar attitude of isolation, we have preferred the straight and narrow path, so as not to become contaminated with life's great burdens that are not intimately interwoven with our professional duties, in so doing we have lost opportunities within the field of sociology. We can ill afford this spirit of aloofness. The voice of the practitioner of medicine must be heard wherever ignorance, superstition and intolerance prevail. He must bear the light and illumine the pathways, dispel darkness and bring hope, faith and inspiration.

We have thus far emphasized the sentiments and the deeds of men of influence, in our profession, who have stimulated us and who have encouraged us in our efforts. We have attempted to show that it is the altruistic attitude which, at all times, governs the true physician in all his dealings with his fellowmen, professionally, as well as privately, but, in a searching and critical analysis of our conduct, we have often had reason to complain of our aloofness. We have failed too frequently to comprehend that, as physicians, not only the problem of the sick were ours to solve, but that we, as intellectuals, have a right, aye, more than that, a sacred duty and a solemn obligation to the people of our State and our Nation, which, at times, we have failed to fully accomplish. How seldom do we participate in public questions of moment! How infrequently do we utter words that might shape the policy of local, city, State or national government! How often do we stand by, when public questions are debated, fearing, perhaps, that contact with politics may involve our professional integrity! America's hope, its future, in fact the future welfare of the civilized world depend upon a virile citizenship. Could such citizenship receive a greater incentive, for bringing about the period for which humanity is praying at the present time, than that which would be guaranteed by our active participation in

governmental affairs? A better, cleaner, more wholesome atmosphere within the domain of politics would thus be created, and our profession could again be exalted for the recognition of its share in the responsibilities that are now facing a people, who are looking for leadership. Gentlemen, let us remember that a new era is upon us. The reconstruction period, owing to the circumstances of war, has materially changed the ordinary tranquil conditions. We must dedicate ourselves to the solving of problems, particularly those relating to social service, which give us unlimited opportunity for the exercise of talents, which, by education and experience, and by the preponderance of the humanities within us, we are particularly fitted for. These opportunities are continually widening, thus, the following health measures are some of the activities that count upon your guidance and support, to wit: Supervision and control of food supplies, urban and rural sanitation, school, social, personal and industrial hygiene. The Workmen's Compensation Act in our State, though somewhat modified by the recent Legislature, is far from satisfactory, and whilst the Act is framed to serve the best interest of our industrial group, it is not generally being faithfully administered, and on all sides there are indications that the ethical conception of its provisions are not adhered to, and if the profession will permit these milder infringements upon our rights to continue, without sounding a note of warning, we will realize, only too soon, that we must come out of the shell and actively participate in politics, so that our representatives will know that we have determined, by a concentrated effort as a united profession, to demand that the altruistic interpretation of said Act by the profession must be enforced and its ethical provisions carried out in every detail.

Under the leadership of Dr. Eagleton and his excellent committee much has been attempted and great success has been accomplished, but, in order that the laws governing health, hygiene, medical licensure, marriage and other subjects, which concern us as a medical profession be of a type pleasing to us and to the best interest of the people of our State, we must see to it that our best efforts be directed in a serious study on the part of those selected by us and, after mature deliberation, by all of us through our professional channels, we uphold the hands of Eagleton, et al., so that no effort of theirs shall be unsuccessful. In other words, we, each of us,

must realize our obligations, as individual members of an honored profession, and cement with dignity our efforts for the benefit of all, bringing about a new epoch, where the influence of the physician, directed in unselfish channels, will be appreciated, heeded, respected and finally acted upon.

Lastly, realizing that the success, the standing and the influence of the physician must come largely through education, medical education received in the hospitals, colleges and universities of our land, let us recognize, in turn, that just as we, in our impressionable years, were enthused by our teachers and leaders and carried their lessons into practice, so must our Alma Mater, depending upon the judgment of her faithful sons, along the professional highways and byways, in the cities and in the country, in the factory and in the hospital and by the bedside, learn and understand that newer methods, more practical problems, are at hand. Discard the impractical and adopt measures calculated to make the study of medicine less theoretical and more practical by bringing the student into closer and more intimate contact with man, so that he may find his physiological bearings and, understanding them, approach the state of pathology with an understanding psychology.

Impress upon mankind the ideals permeating our profession and, by heeding our advice, they will be prompted in so regulating the courses of lectures and instruction, that the humanities in medicine will find a more permanent place in the curriculum, so that its graduates shall enter our profession imbued with its high ideals and lofty conception, eager to serve humanity and, following the example of the men whose names have been mentioned with veneration and respect, propagate their teachings, so that their influence for good may prevail for the everlasting benefit of our profession.

Let the colleges and universities indelibly impress upon the student in his early teaching that ours is a profession singularly devoted to carrying out high ideals, which have placed our profession upon its present strata and that we, as a profession, will zealously guard this honorable calling, which we have obtained at a sacrifice of many who have fallen in the battle, but who have at all times held high its aspirations. Isms and pathies have gradually won the confidence of a substantial group of adherents. In view of these circumstances let us propagate our high stand-

ards and, by sincere endeavor, rally to our cause every reputable physician within the confines of our State, so that our common purpose, *unselfish service to humanity* may have the effect that the thinking people whom we have served may finally comprehend the motives of those who do not desire to abide by the higher educational standards, which we have cheerfully accepted to be the only safeguard for the protection of the health and happiness of the people of New Jersey.

Finally, let our plea to our respective Alma Maters, based upon our individual and collective accomplishments, our loyalty to her efforts and her institution be stated by our firm conviction that the humanities in medicine, emphasized upon culture, will bring to her doors added laurels and to our profession young men who realize the importance of the responsibilities that they are to assume in the field of human endeavor. May our profession, by a keener interest in communal affairs, give added proof for the necessity of carrying on the old, established agencies for human uplift, and may we, by our acts and deeds, inspire men and women to continue their efforts for the general betterment of the physical, mental and moral conditions of our people, thus indicating, by precept and actual example, deeds which are in accord with our avowed purposes, thus demonstrating again our belief in the brotherhood of man, merit the approval of Him on High, in Whom we place our faith, our hopes and our lives.

REFERENCES

- "The Humanities in Medicine," by Charles L. Danna.
- "The Physician Himself," by John F. Finney.
- "Counsel and Ideals," by William Osler.

Hospital Intern Year.—Twelve medical colleges have adopted the requirement of a fifth year to be spent by the student as an intern in an approved hospital or in other acceptable clinical work before the M.D. degree will be granted.

The hospital intern year has been adapted as an essential qualification for license to practice in the following ten states: Pennsylvania, New Jersey, Alaska, Rhode Island, North Dakota, Washington, Illinois, Michigan, Iowa and Delaware.

County Health Officers.—The question of all questions in regard to the county health officer is how to keep the office out of politics. Once the office becomes a question of political patronage, all hope of permanent constructive work is gone.—Allen W. Freeman.

ARE YOUR 1923 DUES PAID?

ORATION IN SURGERY

Historical Review of Ano-Rectal Diseases,
Limitations and Technic of Local An-
esthesia in Recto-Colonic Operations,
Classification and Surgical Treat-
ment of Chronic Diarrhea-Colitis;
Illustrated by Motion Pictures.

Delivered at the 157th Annual Meeting of the
Medical Society of New Jersey at
Atlantic City, June 21-23, 1923.

By **Samuel G. Gant, M.D., LL.D.,**

Author of "Gant on Diseases of the Anus,
Rectum and Colon" and "Gant on Con-
stipation, Obstipation and Intes-
tinal Stasis."

New York City.

Before proceeding with his oration, the writer desires to express his high appreciation to the officers of the meeting, for the compliment bestowed on him by their invitation to address the members of the New Jersey State Medical Society on this occasion.

Certain phases of colo-proctology were chosen for presentation, because the indications for and surgical treatment of chronic diarrhea (colitis) are not sufficiently appreciated, and the limitations and technic of performing various anal, rectal and colonic operations, under local anesthesia, are not fully understood, nor is infiltration anesthesia employed to the extent its merit warrants. Hoping to arouse renewed interest in these subjects, the writer will proceed with their discussion, following a brief historical review of ano-rectal diseases.

HISTORICAL REVIEW OF ANO-RECTAL DISEASES.

I doubt if there is any class of diseases that has a more interesting history than recto-colonic affections, embracing Hebraic, ancient and modern literature.

One of the first records of rectal disease was made by Moses, the law-giver (Deuteronomy XXXIII, 27), who, after mentioning the blessings that would accrue to the faithful, said: "The Lord will smite thee with the botch of Egypt-emerods whereof thou canst not be healed," a disease biblical commentators concede to be hemorrhoids or rectal proclitica. This so frightened the Jews that they were good ever after, and escaped the affliction.

In Samuel I, 6, it is related that the Philistines took the ark from Ebenezer and brought it unto Ashbod; forthwith the Lord smote the men of the cities, large and small, and they had "emerods" (hemorrhoids) in their secret parts. The ark was

removed to Gath and then Ekron, and the plague likewise attacked these cities. Forthwith the people sought their high priests and asked what they must do to be relieved of their afflictions, and were instructed to return the ark of the Lord to the Israelites, together with trespass offerings, consisting of five golden images of the "emerods," according to the number of lords of the Philistines; commands with which they complied and were immediately healed.

Again in Psalm LXXVIII, 66, it says: "He smote his enemies in their hinder parts; He put them to perpetual reproach," and it is probable that from this source arose the present method used by parents in chastening children. From the time of Samuel, three centuries after Moses, to that of the Grecian era or of Hippocrates, more than a thousand years, no further reference is made in literature to "emerods" or hemorrhoids.

Hippocrates held that hemorrhage characterized the disease called hemorrhoids and attributed the trouble to varices of the rectal veins, a view in which Galen and Celsus concurred.

The great historian, Hume, in writing about King Henry, who died in 1422, says he was seized with a fistula, which surgeons of the time had not the skill to cure.

Shakespeare (1606) made fistula famous in his play "*All's Well That Ends Well*," which was based upon the king having a fistula that the daughter of a physician, for a consideration, wished to cure by a secret remedy inherited from her father. Pliny, while discussing fistula, says the disease first showed itself during the reign of Tiberius Cesaer, nor did one man in Rome ever complain of this disorder until the emperor had been attacked by it.

Louis XIV, king of France, suffered from fistula, and after the court physician experiment with itinerant methods upon a number of his subjects thus afflicted, without success, was operated upon and cured by the division method which obtains today. He paid the royal surgeon, Monsieur Felix, and his assistants \$73,500, which, even in these times, would be considered a fairly good fee. It is said that immediately thereafter many persons, who had fistula, and some who did not, flocked to Versailles to be operated on, hoping thereby to attract the attention and sympathy of the king, and during this time fistula became the reigning court disease.

In olden times many deemed rectal diseases incurable, and incurable affections

were considered disgraceful, hence, patients would not disclose them, and this in part accounts for the paucity in literature of rectal ailments over long periods of time. During the present century, especially the last three decades, proctology began to attract the attention it deserves, and rapid progress has been made in the pathology, diagnosis and treatment of ano-rectal affections.

It is a lamentable fact, however, that many surgeons and physicians have not kept pace with time and continued to follow methods of diagnosis and treatment practised in bygone days. Undoubtedly the marked advance made in proctology has been due mainly to Americans specializing in this field of surgery.

Most ancient authorities believed Divine power was a necessary adjunct in the treatment of rectal diseases, but up-to-date physicians do not. Since the Philistines were cured of hemorrhoids by presenting golden image trespass offerings, the people of some far eastern countries have continued to make copper, silver or golden images of afflicted parts and leave them at shrines, hoping through their agency to be healed. Many of the laity in this and other countries still think by carrying an *amulet* that they can prevent or ward-off rectal and other diseases, and we still find Ohians carrying buckeyes or horse-chestnuts, and Missourians shriveled-up potatoes, which they consider a cure for piles. To be effective, however, the potato must be dug *when the moon is right*, and carried in the left trouser pocket until it becomes hard as a stone.

LIMITATIONS AND TECHNIC OF LOCAL ANESTHESIA IN RECTO-COLONIC OPERATIONS.

In a series of cases, including anal, rectal, colonic and abdominal operations, different forms of anesthesia are necessary, and the operator must choose between *general*, *spinal*, *sacral*, *regional* or *infiltration* anesthesia, according to his preference and the requirements of the case.

General narcosis, induced by nitrous-oxide, gas-oxygen, ethyl-chloride, ether, chloroform or gas-ether, has been successfully employed by the writer in cases in which local anesthesia was impractical, but he prefers gas-ether in the majority of lengthy ano-rectal and abdominal operations, because when properly administered it invariably induces complete anesthesia.

General narcosis is *contra-indicated* in approximately 80 per cent. of ano-rectal

and many abdominal operations, because (a) it is dangerous unless the anesthetic is administered by an expert; (b) it alarms the patient by rendering him unconscious; (c) it causes post-operative nausea, vomiting and straining; (d) it may aggravate heart, kidney and pulmonary lesions; (e) and necessitates the patient remaining in the hospital or at home, and is a frequent cause of post-operative, ano-rectal hemorrhage, owing to the patient throwing himself about, increasing intra-abdominal pressure by vomiting, straining or withdrawing dressings, while unconscious.

In the writer's practice, alarming bleeding has occurred ten times more frequently following operations performed under *general* than *infiltration* anesthesia, and post-operative pain has been encountered more frequently and severely after former than the latter.

Spinal Anesthesia.—Analgesia induced in this way has been effective in many upper and lower abdominal, pelvic, urinary and ano-rectal operations performed by different operators, but the procedure has not attained general popularity since (1) anesthesia is incomplete, when the needle fails to enter the cord; (2) dosage is insufficient; (3) the solution is improperly prepared, and (4) when the patient has an idiosyncrasy to this form of anesthesia.

With few exceptions, surgeons hesitate to employ spinal anesthesia, because it has induced sudden death, paralysis, occipital headache, vertigo, backache, respiratory disturbances, neuritis, vesical and rectal incontinence and acetoneuria, with discomforting frequency.

The following are the advantages of spinal anesthesia—the patient remains conscious, and nausea, vomiting, shock, bronchial irritation, nephritis and gastro-intestinal irritation rarely, if ever, occur, and operations are facilitated through accompanying relaxation of tissues and muscles in the operative field. *Tropacocaine*, *novocaine*, or *stovaine*, preferably employed, dissolved in the spinal fluid, are the anesthetics of choice.

Sacral Anesthesia.—Caudal is not as dangerous nor so frequently followed by distressing complications, as spinal anesthesia. Entrance to the sacral canal is easy in some and difficult in other instances. Following anesthetization of outer structures and placing of the patient in the left Sim's or exaggerated knee-chest posture, the needle is forced through the *hiatus-canal*, or triangular space at the fork of

the spinous processes, above the anal sulcus, which gives an elastic touch when pressed upon with the finger. As soon as the canal is entered, the needle is carried upward the desired distance and the solution discharged; the dosage being varied, according to weight and age of the patient. Sacral anesthesia is not as effective as spinal, and requires several minutes longer to obtain than infiltration analgesia.

Regional Anesthesia.—Nerve-blocking anesthesia, unless induced by spinal or sacral injections, is not suitable for ano-rectal surgery, since controlling nerves are numerous, small and difficult or impossible to locate, and further because infiltration analgesia, universally satisfactory, is more easily and quickly induced.

Local (Infiltration) Anesthesia.—Since 1900, about 80 per cent. of the writer's private and clinic ano-rectal, and a considerable number of abdominal operations have been performed under infiltration anesthesia, induced by sterile water, normal salt solution, eucaine, novocaine and other anesthetic agents, with satisfactory results. He has operated 5,000 times under local anesthesia, without a death, dangerous toxic manifestation or other serious complication.

In the beginning, owing to imperfect technic and employment of solutions of different strengths, patient occasionally squirmed or complained of pain, and in a few instances general anesthesia was substituted for local analgesia, complications rarely encountered in the last fifteen years, since the present technic has been perfected.

The scope of infiltration anesthesia has been greatly extended, and physicians, surgeons and proctologists, who do not perfect their technic and employ it largely to the exclusion of general narcosis, do not deserve the patronage of patients afflicted with minor ano-rectal affections.

Infiltration anesthesia possesses many desirable features, but has its limitations. The writer never employs it, except when he has ascertained before hand *what is to be done*, and discards the method for spinal or gas-ether anesthesia, for extensive, deep operations, in which an *unknown* amount of cutting may be required.

General anesthesia is also preferred in minor affections, complicated by a high or more serious rectal disease, and when tissues are necrotic or there is an ulcer or fistulous opening that prevents retention in and desensitization of the tissues by the anesthetizing solution.

To aid the reader in forming an opinion concerning indications for *general* and *local* anesthesia in this class of work, the writer has grouped affections most frequently encountered about the terminal bowel as follows:

(a) Ano-rectal diseases *operable*, under local anesthesia.

(b) Ano-rectal diseases *inoperable*, under local anesthesia.

ANO-RECTAL DISEASES OPERABLE UNDER LOCAL ANESTHESIA.

Internal, protruding, bleeding, capillary and combination; external, cutaneous and thrombotic hemorrhoids; fissure-in-ano, ulcers of the anal canal, single and multiple, superficial, long and short fistulae; procidentia-recti (first and second degree), cryptitis, inflamed and hypertrophied and papillae, hypertrophied rectal valves, marginal, submucous and most ischio-rectal abscesses; polyps, strictures (below the peritoneal attachments), foreign bodies (imbedded beneath mucosa or skin), constipation, incident to sphincter-algia, hypertrophy of the levator-ani muscle or narrow anal canal, intra-rectal diverticula and cysts, incipient anal epithelioma, peri-anal cysts, tumors and condylomata; fecal impaction, pruritus-ani, sacral dimples, dermoids and fistulae, fecal incontinence, repair of ano-rectal injuries and sequelae to operations for congenital malformations.

The writer has many times performed *exploratory celiotomy, colostomy, appendicostomy, cecostomy, ileostomy, sigmoid-ectomy, colopexy, uterine suspension* and other *abdominal operations*, including *breaking up of adhesions, straightening Lane's kinks, division of Jackson's membranes and colo-plication*, under infiltration anesthesia.

He has also relieved *acute intestinal obstruction* by opening the abdomen and draining the bowel, under local anesthesia, and has several times performed the *secondary* operations of excising the gut opening the cecum or small intestine or amputating the appendix in connection with *colostomy, cecostomy, ileostomy* or *appendicostomy*.

In some, the operation was entirely painless, while in other instances the patient suffered slightly on incision of the fascia, peritoneum, or pulling upon the mesentery.

Experiments with infiltration anesthesia has convinced the wrater that *general* (gas-ether or gas-oxygen) is preferable to *local* anesthesia, for deep and abdominal opera-

tions, in which considerable handling of the intestines or viscera is required.

ANO-RECTAL DISEASES INOPERABLE UNDER LOCAL ANESTHESIA.

Cancer (barring beginning and epithelioma), *extensive peri-rectal and ischio-rectal abscesses, deep, burrowing complicated horseshoe, peri-rectal, recto-urethral, recto-vaginal and vesico-rectal fistulae, high polyps structures, ulcers, cysts, non-malignant tumors and imbedded foreign bodies, submucous abscesses and fistulae* in the upper rectum, and *any disease or injury requiring amputation or resection of the lower bowel.*

General is also preferable to local anesthesia for procedures and plastic operations that require extensive stitching in and about the rectum, except those employed in the radical treatment of fistulae and hemorrhoids, and is desirable when a minor is complicated by a more serious rectal affection. lesions that cannot be brought into view for operation and deep, abdominal or operations requiring traction upon the mesentery.

A study of the diseases included in the above lists show that approximately 80 per cent. of ano-rectal affections are located within easy reach and are capable of being operated upon under local anesthesia.

POSTURE, EQUIPMENT, AGENTS AND METHODS.

Posture.—The exaggerated *knee-chest, lithotomy or left Sim's* posture may be employed, but the writer prefers the latter, because it is convenient for him and comfortable for the patient during short or long operations upon the buttocks, anus or lower rectum.

Syringe.—A metal syringe, having a Gant goose-neck attachment, is preferable to a glass syringe, which breaks easily or leaks under pressure during skin fistula and structure operations, in which tissues are dense. Small needles are objectionable, because they readily break or become blocked by corrosion or ingredients in the solution.

Local Anesthetics.—Anesthetizing agents save the patient considerable suffering in both the *palliative* and *operative* treatment of ano-rectal disease.

Palliative Treatment.—Suffering, incident to examination, instrumentation, cauterization and treatment of sensitive individuals may be prevented or minimized by placing a pledget of cotton soaked in a 10 per cent. solution of eucaïne, cocaine or novocaine upon lesions in the mucosa or

peri-anal skin and letting it rest there for a few moments. These agents do not induce complete anesthesia here, as in the throat, but effectively desensitize the part, when injected into or beneath the sensitive area in a $\frac{1}{8}$ of 1 per cent. eucaïne solution.

Orthoform, alypin, anesthesin and analgin, possessing analgesic and healing properties, markedly diminish pain and muscular irritability, incident to walking, sitting, defecation and treatment of local lesions, when employed in a powder, suppository, solution or ointment, and deserve a place in the armamentarium of the proctologist.

Eucaïne and cocaine solutions are also useful for mitigating and arresting unbearable itching—*pruritus-ani*—when skin is raw.

Operative Treatment.—Numerous agents have been employed for ano-rectal operations, viz: *Ether-spray, liquid air, ethyl-chloride, eucaïne, cocaine, stovaine, novocaine, tropacocaine, sterile water, normal saline solution, quinine and urea, hemesia and apothesine.*

Ether-Spray, Ethyl-Chloride and Liquid Air.—These agents deaden or prevent cutting pain by freezing and benumbing tissues, but are unsatisfactory, because they induce acute initial and post-operative suffering, are often followed by sloughing, and when effective induce only *superficial anesthesia*, which limits their employment to *light incisions* in the mucosa and skin.

Eucaïne, Cocaine, Stovaine and Tropacocaine.—These agents have their respective adherents and have been successfully employed in varying strengths to produce spinal, para-vertebral, regional and local anesthesia for ano-rectal, pelvic and abdominal operations.

These drugs, *particularly cocaine*, often produced annoying or alarming toxic manifestations when use in a *strong* (3 to 10 per cent.) solution; but in a *weak* solution they are effective and seldom disturb the patient when injected in small amounts. The majority of operators employ from a $\frac{1}{2}$ of 1 to a 2 per cent. solution, which is stronger than required to produce complete desensitization of tissues.

Extensive experiments made in 1900 convinced the writer that the anesthetizing action of the solution is due both to the *contained chemical and distension of tissues with compression of the nerves*; for he observed that infiltration anesthesia failed or was incomplete when part or all the fluid escaped through a needle puncture, necrotic tissue, ulcer, or fistulous opening and

demonstrated by hundreds of ano-rectal operations, performed under sterile water and normal saline infiltration, that analgesia immediately follows when tissues are distended with the fluid until *glassy-white* which indicates complete anesthesia.

Repeated experiments with eucaine, cocaine, stovaine, novocaine, tropacocaine and like agents satisfied the writer that *eucaine* and *novocaine* are the anesthetics of choice. During the last fifteen years he has operated five thousand times without an accident or failing to obtain complete anesthesia with eucaine 1-8 of 1 per cent. solution, and these patients were able to walk from the operating room to their beds and rarely exhibited toxic manifestations irrespective of the anesthetic employed.

The addition of adrenalin (1 to 1000) extends duration of analgesia and lessens hemorrhage during operation, but the writer seldom employs it because blood-vessels, temporarily constricted, later relax and bleed freely and he prefers that hemorrhage should take place during operation so that it may be immediately controlled.

Sterile Water and Normal Saline Solution.—During the period 1900-1905 the writer published a series of papers giving the technic of *distension anesthesia* induced by the injection of sterile water and normal saline solution, and reported several hundred ano-rectal operations successfully performed under these agents. Subsequently sterile water was abandoned for eucaine anesthesia because the initial injection of the former induced slight pain.

Quinine and Urea Hydrochloride.—This anesthetic is effective, non-toxic, suitable for long and short operations and minimizes post-operative pain. The solution when injected causes greater pain than eucaine or novocaine and takes minutes longer to induce complete analgesia. Quinine and urea is not desirable for skin operations since it sometimes causes induration or sloughing of the integument and delays healing. It induces anesthesia when employed in a $\frac{1}{2}$ to 1 per cent. solution. The writer sometimes employs this agent in the clinic or office when operating on patients desiring to return home.

Apothesine, which is practically non-toxic, has been successfully employed in a $\frac{1}{2}$ to 1 per cent. solution, but requires a longer time to induce analgesia than eucaine or novocaine.

Varying sensibilities of different patients have nothing to do with results obtained, nor does success of the anesthetization de-

pend entirely upon the anesthesia employed, for good or bad results depend on whether or not the anesthetizing agent is retained in the tissues, and a sufficient quantity of the solution is injected to cause a round or linear *whitish swelling* over the part to be incised.

The amount of sterile water or anesthetic employed varies from a few drops to one or more ounces, depending on resistance of tissues and extent of the operation. *For example*, four to six drops suffice for the removal of *hypertrophied anal papillae*, *inflamed crypts* and *small polyps*, a half for external *cutaneous thrombotic piles* and one drachm or more for *fissure*, and *medium sized* or large *internal hemorrhoids*, from half to an ounce or more for *fistulotomy*, *low strictures*, *Gant's pruritus* and *proctidia-recti operations* and *divulsion of the sphincter*.

Before proceeding the writer tells all patients that the preliminary injections will cause discomfort but that the operation will not, otherwise they squirm at the needle puncture.

In skin operations, after the initial injection consisting of one or two drops is made *intercutaneously forming a bleb*, the solution is slowly deposited subcutaneously into the operative field until tissues are distended *glassy-white*, an invariable indication of analgesia.

To obtain effective anesthesia it is essential that the operator avoid multiple unnecessary needle punctures, fissures, ulcers, and fistulous tracts, otherwise pressure action of the solution upon nerves is lost, owing to escape of the fluid through the openings.

The operator must also work quickly since the solution, when properly prepared and injected, induces anesthesia within a few seconds and analgesia lasts only a few moments.

The writer has heard surgeons say they objected to infiltration anesthesia in ano-rectal operations, because patients squirmed, complained of severe pain or fainting, annoyances rarely encountered by him, whose results have been universally satisfactory to the patient and himself. He is certain that unsatisfactory results reported by some operations would not have occurred had they understood the technic of infiltration anesthesia, employed *weak* in preference to *strong* solutions of eucaine or novocaine, and used tact with their patients.

He regrets to state that it appears from conversations with some surgeons that they do not employ local anesthesia in this class

of work, because they fear their fee would be less than if they employed general narcosis, put the patient in a private room, required him to engage night and day nurses and remain in the hospital for one or more weeks.

To such physicians he would say that both the number of patients and size of fees received from them have materially increased since he began employing *local* in preference to *general* anesthesia.

The writer is fully convinced that should proctologists and surgeons become proficient in the technic and employ local anesthesia to the extent deserved they would be able to perform many ano-rectal operations, now considered impossible except under general narcosis and because of this would quickly eliminate advertising quacks from this field of surgery.

Hemorrhoids are *exposed* or extruded for infiltration with the aid of a slide speculum or tipping them out with the end of a Gant speculum as the instrument is withdrawn, everting anal margins with fingers, withdrawing them by cupping, administering a small enema and extruding them by pulling on tampons introduced into the rectum through a proctoscope.

In completing the operation if there is copious oozing or spurting vessels, hemorrhage is controlled by a twisted gauze plug inserted through a proctoscope which, when withdrawn leaves it projecting through the anus.

Post-Operative Treatment.—Following an average hemorrhoidal or fissure operation and excision of papillae, crypts, and polyps, the patient is permitted to leave the hospital in two or three days or when he can comfortably come to the office in a taxi for dressings. These patients are allowed a regular diet and normal stools are sought with fruit or a mild laxative.

Post-Operative pain is practically *nil* in *intra-rectal* but is severe in extensive *skin*, operations and lasts from half to two hours unless controlled by morphine administered hypodermically in one-quarter doses, as often as required.

Local Anesthesia in Abdominal Operation

Infiltration anesthesia is not so universally satisfactory for abdominal as ano-rectal and surface operations where nearly always it is effective. The procedure is contra-indicated in this class of operations unless the operator knows beforehand just what is to be done, and local anesthesia is not suitable for many deep abdominal and pelvic lesions, extraction of tumors when viscera are matted together by adhesions

and where there are complicating diseases within the abdomen.

The writer has performed fifty-five abdominal operations including *appendicostomies*, *cecostomies*, *enterostomies*, *colostomies*, *cecopexies*, *cecoplications*, *colotomy*, *sigmoidopexies*, and operations for *Jackson's membranes*, *Lanc's kink*, *adhesions* and *angulations*, some of which were performed under sterile water anesthesia and reported in a series of papers published between 1902-1905.

The majority of the above named procedures are adaptable to local anesthesia because deep exploration is often unnecessary, pulling upon sensitive mesentery is required and pinching, cutting and suturing of the unanesthetized cut causes little or no pain. Discomfort from the majority of these operations is avoided by the expert in local anesthesia, who carefully prepares and injects his solution slowly and cautiously, infiltrates each abdominal layer (from skin to peritoneum) *separately*, which usually requires about three minutes each for the skin, subcutaneous structures, muscles, fascia and peritoneum.

The principles in abdominal infiltration are, in the main, the same as those employed in local anesthesia for ano-rectal operations already described and the analgesic action of the anesthesia is due both to distension pressure on nerves and the chemical contained in the solution.

The writer prescribes morphine gr. $\frac{1}{4}$ and scopolamine gr. 1-200 one hour preceding, and repeats the dose fifteen minutes before abdominal local anesthesia operations in robust individuals to blunt consciousness and quiet apprehension in nervous patients.

Technic.—Careful study of the accompanying illustrations, with its descriptive legend explains the manner in which abdominal local anesthesia is accomplished by the writer and renders further description of the technic unnecessary.

Analgesia is more effective when the anesthetic is used liberally and the solution is slowly diffused into the operative field. Satisfactory surgical analgesia is produced with a eucaine $\frac{1}{8}$, novacine $\frac{1}{2}$ of 1, or apothesine 1 per cent. solution in combination with adrenalin (1-1000) which quickens and lengthens action of the anesthetic, with but little danger of causing toxic manifestations even when the solution is used freely.

Classification and Surgical Treatment of Chronic Diarrhea-Colities.

Classification.—There are many types of

chronic diarrhea, some are considered medical, since they are induced by diseases curable by dieting, medication, rest in bed, change of climate or surroundings and medicated irrigations introduced *per anum*, while others are classified as *surgical*, because an operation *plus* through and through colonic irrigations, or putting the bowel completely at rest by an operation that prevents feces reaching lesions in the diseased bowel responsible for loose movements is indicated.

Diseases Responsible For Diarrhea Curable By Medication.—This group includes persistent diarrhea induced by organic diseases—buccal, dental, nasal pharyngeal, gastrogenic, enterogenic, neurogenic, urogenic, hepatogenic, intestinal amyloidosis, pellagra, sprue, obesity, alcoholism, gourmandizing, daily consuming cold drinks or ices, eating irregularly, prolonged catharsis chemical and ptomaine poisoning, psychic disturbances, typhoid, typhus and relapsing fever.

Catarrhal and infectious types of colitis mentioned later should be regarded as and treated *medically* so long as the patient shows decided improvement from non-operative measures. However, when following weeks, months or years of treatment including dieting, medication, rest, and colonic lavage *per anum* diarrhea persists or recurs at short intervals, the affection responsible for it has become surgical and must be so treated if the patient is to be permanently cured.

Occasionally some of the above diseases fail to respond to medication and the intestinal mucosa through the frequent passage over it of improperly balanced gastrointestinal juices, undigested food remnants and medicines prescribed to relieve the condition becomes *extremely irritable, eroded, or ulcerated* when an operation reinforced by medication and through and through irrigation is indicated.

Diseases Responsible for Diarrhea Requiring Surgical Intervention.—Every disease causing intestinal inflammation, ulceration or obstruction responsible for chronic diarrhea, muco-purulent discharges, hemorrhage, sepsis, and malnutrition, that fails to respond to medical treatment within a reasonable time, should be treated surgically.

Surgical colitis is usually induced by chronic *catarrhal* or *infectious ulceration* involving the colonic and rectal mucosa though in exceptional cases the disease involves both the small and large intestine (entero-colitis).

Named in order of their importance the following are the varieties of *ulcerative colitis* most frequently responsible for chronic surgical diarrhea:

(1) Catarrhal Colitis, the etiology of which is uncertain.

(2) Tubercular Colitis, usually secondary to pulmonary infection caused by Tubercle Bacilli.

(3) Amebic Colitis, induced by *Amebae Histolytica*.

(4) Bacillary Colitis, caused by Shiga, Kruse, Flexner, Duval or so-called Dysenteric Bacilli.

(5) Balantidic Colitis, the result of infection by *Balantidium Coli*.

(6) Helminthic Colitis, incident to Tape (cestode) or round (nematode) Worms.

(7) Flagellate Colitis, incited by *Cercomonas Hominis*, *Trichomonas Hominis* or *Lambliia Intestinalis*.

(8) Coccidic Colitis, caused by *Coccidium Curriculi*, *C. Hominis* or *C. Bigenium*.

(9) Syphilitic (luetical) Colitis, induced by *Spirocheta Pallida*.

(10) Gonorrheal Colitis, caused by *Gonococci*.

Occasionally two or more types of infection prevail in the same case of colitis each aggravating or prolonging loose movements, but with few exceptions the treatment need not be modified because of this, since both conditions are simultaneously curable with the aid of *appendicostomy cecostomy* or *Gant's Ileo-cecostomy* and through-and-through colonic irrigations or providing physiological rest for the bowel by performing *intestinal exclusion, ileostomy* or *colostomy* in deplorable cases complicated by polyposis or obstruction.

Operative Treatment of Ulcerative Colitis.

The following are the procedures most frequently indicated in the operative treatment of *ulcerative colitis* with or without *polyposis* (multiple adenomata) also loose movements induced by chronic intestinal obstruction:

1, Appendicostomy; 2, cecostomy; 3, appendico-cecostomy; 4, ileo-cecostomy — Gant's operation; 5, intestinal exclusion; 6, ileostomy; 7, colostomy; 8, colectomy.

Appendicostomy or *Cecostomy* reinforced by through-and-through irrigation, is indicated when the *colon* only is involved: Gant's *ileocecostomy* is employed when both the ileum and large intestine are involved in the inflammatory process; intestinal exclusion is resorted to in the

treatment of ulcerative colitis complicated by Polyposis.

Ileo-ostomy or Colostomy (Gant) is performed in cases of chronic diarrhea induced by tumors or other varieties of chronic intestinal occlusion and *Colectomy* is practised as a last resort in deplorable cases of ulcerative colitis complicated by polyposis or obstructive lesions that have permanently destroyed the functioning power of the colon.

Appendicostomy.—Appendicostomy, the operation of choice in lean and moderately thin individuals, who have not previously submitted to an appendectomy when the appendix has not been rendered unfit through being too short or small, strictured, kinked or otherwise diseased, since there is less danger to leakage and infection, following appendicostomy than cecostomy, and because cecal are more difficult to close than appendiceal openings.

Technic.—The procedure is simple and the appendix may be brought out through an *intermuscular* incision and anchored to the skin in the region of McBurney's point, but the writer prefers his *stab-wound appendicostomy* embracing the following steps.

(1) the abdomen is opened by a three inch incision at the outer border of the rectus, the muscle is retracted inward and wound edges protected with gauze handkerchiefs; (2) cecum and appendix are located, freed, brought to the surface and cecal suspension sutures introduced; (3) cecum is sacrificed, the appendix straightened by dividing adhesions and mesentery at a safe distance from the artery and suspension stitches placed one inch apart are carried through the abdominal wall of the cecal region with a long handled needle; (4) with first and second fingers introduced as a guide a free stab-wound is made in the abdominal wall at McBurney's point and the appendix is withdrawn through it with the aid of long curved forceps; (5) suspension sutures are tied across rubber tubing, angle stitches* (of linen or chromic gut) are introduced and tied on either side of the appendix and the abdominal wound closed; (6) the appendix is bent over and covered first with rubber tissue smeared with vaseline and gauze and the operation completed by placing outer dressings over the closed stab and abdominal wounds.

To avoid possible infection the appendix is not opened for a few days when it is amputated a short distance above the skin under local anesthesia. In aggravated cases of colitis complicated by malnutrition mark-

ed loss in weight, persistent loose movements and hemorrhages the appendix is removed while the patient is on the operating table, a Gant soft rubber *appendiceal irrigator*, is inserted and colon immediately flushed with a 5 per cent. ichthyol solution and daily thereafter for a week, when a milder solution is employed.

Cecostomy is indicated in the same class of cases as appendicostomy. In Gant's stab-wound operation the steps in the procedure are similar to his appendicostomy described above. Since the cecum is approached through a right rectus incision and the catheter leading from it is brought out and fixed to the skin through a stab-wound made over the caput coli; to avoid the tendency of subsequent leakage the writer forms an inverted circular valve about the inserted tube by three purse-string sutures which when tied infold the bowel about it, the catheter is then bent at a right angle and the anterior cecal wall plicated over it before the tube is withdrawn through the stab opening.

The operation is completed by closing abdominal and stab-wounds, anchoring the catheter to the skin with adhesive straps applied in a special manner and closing the catheter with a cravat clamp to prevent the escape of gas and feces.

Appendico-Cecostomy.—When attempting appendicostomy and the organ is found unfit for the purpose the appendix is amputated half an inch external to the cecum and one end of the catheter is introduced through the stump and the catheter brought out through a stab-wound as in cecostomy, a procedure designated appendicostomy.

Gant's Ileo-Cecostomy.—This procedure was designed by the writer as a substitute for appendicostomy and cecostomy in cases in which both the ileum and colon are involved in the ulcerative process, since it provides for *simultaneous* or *separate irrigation* of both the small and large intestine which cannot be successfully accomplished through an appendiceal or cecal opening.

Briefly described the following comprise the steps in Gant's ileocecostomy:

(1). Through a two inch intermuscular right rectus incision the ileo-colic angle is withdrawn and wound edges protected with gauze handkerchiefs; (2) ascending colon and ileum are clamped to prevent soiling of the wound when the bowel is opened and the cecum sacrificed; (3) linen purse-string sutures are introduced opposite the ileo-cecal valve and the gut opened inside the suture line; (4) holding the bowel so

the ileo-cecal valve rests between thumb and fingers of the left hand, a Gant catheter guide is passed across the cecum through the ileo-cecal valve into the small intestine; (5) the obturator is removed and a catheter inserted through the guide into the small bowel; (6) a short piece of rubber tubing is projected into the cecum beside the first catheter; (7) infolding purse-string sutures are tied, forming a cone-shaped valve about the catheters which subsequently prevents leakage of gas and feces; (8) clamps are removed and the cecum anchored to the transversalis fascia denuded of peritoneum by suspension sutures passed through the abdominal wall and tied across rubber tubing; (9) the wound is closed and catheters anchored by skin sutures or an encircling crossed by a second adhesive strip; (10) tubes are closed with cravat clamps to prevent leakage and the operation completed by applying gauze pads about the tubes and over the closed wound.

Catheters are then marked that interne and nurse may know which is in the large and which is in the small intestine, when time for irrigating arrives.

To avoid possible wound infection flushing is not begun for a few days, unless diarrhea, hemorrhage or toxic manifestations are alarming. To facilitate operation, dispense with soft catheters that might be expelled by peristaltic contraction and insure the solution's entering and being retained in the small intestine, the writer devised a soft rubber entero-colonic irrigator which he used to advantage in several cases.

When the irrigator is in position the inflated bag rests in the small gut against the ileo-cecal valve and when distended temporarily prevents escape of the irrigant from the small gut into the cecum.

With this twin tube irrigator the small and large intestine can be separately or simultaneously irrigated by physician, nurse or patient. Steps in the writer's ileo-cecostomy when the irrigator is used are the same as when catheters are employed, except a catheter guide is unnecessary.

Irrigating Solution.—The beneficial action of through and through irrigation is due almost as much to *mechanical* action of the fluid in cleansing the inflamed and ulcerated mucosa of irritating feces, discharges and pathogenic organisms, as to contained *medication*.

Catarrhal colitis rapidly improves following daily flushing with normal saline, but when there is more or less ulceration, hemorrhages and abundant discharges and frequent evacuations stimulating antiseptic

and astringent irrigations are employed morning and afternoon until improvement is marked when irrigation once daily suffices.

In neglected cases complicated by extensive ulceration, severe diarrhea and hemorrhage, the writer begins with silver nitrate, grs. xxx to the quart, followed by a normal saline irrigation later the silver is gradually diminished until grs. v are employed or another irrigant is substituted, viz.: A 4 per cent. boric acid, 2 per cent. ichthyol, 3 per cent. balsam of Peru, 1 per cent. permanganate or 5 per cent. argyrol solution.

When there is an abundance of pus or debris, peroxid of hydrogen 20 per cent., is useful and quinine bisulphate 1-1,000 may be tried in entamebic colitis, but is not so reliable, as the above irrigants.

The following combination may be relied upon:

℞ Fl. ext. Krameria.....3iv
Baborate of Soda.....3ii

M. Sig.—A tablespoonful to a quart of warm water and irrigate once or twice daily.

The above alternated with an emulsion composed of bismuth 3j and olive oil is soothing and does much towards lessening peristalsis, eliminating inflammation and soreness, healing ulcers and minimizing tenesmus when alternated with one of the above irrigating solutions.

Hot Irrigants.—100°-110°F. are soothing and preferable to cold—65°F.—which incite intestinal contractions that expel medication before it has accomplished its purpose.

The amount of medicated fluid is varied, according to indications, but two quarts allowed to run in slowly, with hips elevated, is usually sufficient. A larger quantity, two to four quarts, is employed to advantage in aggravated cases to cleanse colonic lesions of irritating discharges and debris, but when a large amount of solution is used, a small proctoscope is introduced through the anus to permit escape, as it runs in, which prevents colonic distention and possible ptosis.

When *appendicostomy* and *cecostomy* and direct bowel treatment fail, it is because of a serious complicating ailment, the bowel is diseased above the colon or the patient's position is not frequently changed during treatment that the irrigant may reach *all lesions on all sides of the bowel*.

This method of treating chronic diarrhea responds more quickly when reinforced by

vided, one end closed and the other joined to the sigmoid or rectum by end-to-end or side-to-side anastomosis.

At first movements are fluid and frequent, but later, as the ileum functionates for the colon, stools occur less frequently and become firm. Colonic exclusion is preferable to colostomy, because evacuations are voided *per anum* and disgusting features of having an artificial anus in the abdomen are avoided.

Interostomy and Colostomy.—Occasionally the formation of an artificial anus is imperative to put the bowel at rest and provide for irrigation of the diseased gut, particularly when the colon is riddled with numerous, extensive, deep ulcers and submucous fistulae with or without complicating *polyposis* or stenoses.

Ileostomy, because of consequent fluid evacuations that erode the skin and constantly annoy the patient, is resorted to only in extreme cases, where both ileum and colon are involved in the destructive process.

Ileostomy and particularly colectomy are more often performed for the relief of diarrhea, induced by obstructive lesions—*stricture, cancer, kinks* and other *blocking lesions* within or without the bowel—than for catarrhal or infection colo-proctitis.

Colostomy is a useful procedure in suitable cases, but is not indicated nearly so frequently as appendicostomy and cecostomy in the treatment of chronic diarrhea, and is not employed in ulcerative colitis unless the above procedures have failed or the patient is rapidly being exhausted from frequent copious hemorrhages or both ulcers and tumors involving the colon.

In such cases the artificial anus to be effective must be located above the lesions that the diseased segment of gut may be put at rest and frequently irrigated.

The writer's colostomized patients seldom complain of frequent involuntary movements, because partial or complete control over them is accomplished by forming a medium-sized anus after adjacent muscles have been snugly sutured about it and the gut has been twisted, carried under, brought through and attached to the skin, with the aid of a cut made two or three inches to the right or left of the original incision. When there is a tendency to frequent involuntary movements, the writer's soft rubber dumbbell-shaped bag, is effective.

To avoid possible infection of the wound or abdomen, the projecting bowel is not amputated for several days, unless obstruc-

tive manifestations are urgent or the patient is in a dangerous condition from repeated hemorrhages.

Colectomy.—This procedure is indicated more frequently in the treatment of surgical diarrhea than chronic constipation, but is seldom called for in either case. One is not justified in removing the colon for persistent diarrhea until medical treatment and other less radical surgical procedures have failed to control exhaustive loose movements, depleting hemorrhages, anemia, malnutrition and stop the growth of papillomata upon the extensively inflamed mucosa.

In other words, colectomy is unjustified in this class of cases unless functioning power in the large intestine has been destroyed by the ulcerative process or is seriously occluded by polyps, structure, cancer or other obstructive lesions.

The technic of colectomy has been omitted for lack of time and because the writer in his works* has fully described and illustrated the operation.

In conclusion, the writer would say he believes that if surgeons would pay special attention to the class of diseases and operations herein discussed they would be amply repaid for the time spent.

471 Park avenue, New York City.

DISCUSSION

Dr. A. Haines Lippincott, Camden.—Mr. President and Gentlemen: I am certainly sorry that this most excellent address of the doctor's was not put on the program earlier. Dr. Gant possibly has done more to divert rectal cases away from the hands of the charlatan than anybody in this country. His development and writing on the application of local anesthesia in rectal work has been a great benefit and addition to the medical profession. As to his abdominal work I cannot speak very much on that line, because my experience has been more or less limited. I have had some little experience in cecostomy and in appendicostomy in a few cases, in the ulcerative form of colitis, and in my hand it has been a difficult condition to remedy or even to improve by local application through a proctoscope or sigmoidoscope, and it does seem to me that the surgical interference, as the doctor described, is the proper method by which to attack these cases.

I have in mind the case of a young lady, who, for a number of years, had an ulcerative colitis. Just what was the cause of her condition we never did find out, but I believed from the beginning and until today that it was a case of tuberculous ulcerative colitis. She had gone the rounds for many years. She was a young girl, when she was practically isolated in her room, taken away from the social affairs that she was so fond of, and was mentally and in every other way a great sufferer. In her case I think it was a cecos-

tomy that we did, and we got almost remarkable results in the beginning of the irrigations, and it was to me a striking illustration of the application of this method of treatment. Undoubtedly our technique was not as complete as the doctor's, because, following her cecostomy and following the stage of the process that we considered her cured, she had a distressing fecal fistula. But she was constantly asking me to continue the case and close this fistula. However, I did, as I hear Dr. Gant today advised—I kept my hands off.

That part of Dr. Gant's address where he spoke of taking plenty of time to close your appendicostomy or cecostomy wound, I consider a very important part of the treatment, and I think it was what saved us in this case, because I constantly avoided any further interference until several months after the wound was made, or the time we considered she was well. We then operated on the fistula with very happy results, and today this girl is back to good health; has gained flesh and has taken up her social activities with a great deal of pleasure. Now I am doing more and more rectal work under local anesthesia, and I remember well that when I first heard Dr. Gant speak of his operations under the sterile water injections, depending upon the pressure of the fluid to give him his anesthesia, Dr. Brick and I took a trip through the New York Post Graduate and saw the doctor operate under sterile water anesthesia, and we came home highly enthusiastic—no more ucin to buy—and we were firm believers in this method. The first patient we had, unfortunately, was an Atlantic City doctor, and after our operation the doctor was not as enthusiastic, and neither was Dr. Brick nor I about the local anesthesia under water, because, of course, we did not do it as Dr. Gant could do it, and the doctor did have a lot of pain, but in spite of his suffering we got results. It was an ordinary hemorrhoid case. I am doing more and more rectal work under local anesthesia and the ligature operation, and since the issuance of Dr. Gant's latest work I have done even more, and I think after today I will do more still. Of course, the majority of our ward cases that are sent into the hospital are submitted to the clamp and cautery operation, and it is done under general anesthesia. I do not do the Whitehead operation, because of the after-conditions that often follow, as Dr. Gant has described to you. I have seen a great many of them. I am, I must say, fond of the clamp and cautery operation, because our patients do not have much post-operative pain. It has been a long, long time since I have had hemorrhage that has called me back to the hospital, and the patients are usually out of the hospital within four or five days.

I would like to ask Dr. Gant if he does much of the hemorrhoid (I know he does mostly all of his simple fistulas) operations, where there are multiple hemorrhoids, under local anesthesia with a ligature, and if they are satisfactory; in multiple hemorrhoids, whether he continues and cleans up the whole condition? I have enjoyed this discourse of the doctor's thoroughly on a condition of diseases that have until recently been treated

mostly by the charlatan and the quack. Until recently the doctors have been sending these cases out of their offices and they have drifted into the hands of the charlatan. I thank the doctor for what he has done, more than any one else, to give these patients relief, and I am very glad to have heard his presentation.

Dr. Crichton, Newark: I feel that Dr. Gant is in rather a peculiar position for a younger man. Those of us who do proctology in this country, at least east of Chicago, give Dr. Gant the credit for being the dean of this particular branch of medicine. Whenever I hear Dr. Gant talk or have an opportunity to hear him demonstrate to a class or to a number of medical men, all of this appears as though it can be done by everybody and done at once, and everybody becomes an expert at very short notice. However, local anesthesia is not as simple to every one as it is to Dr. Gant right off the reel, and it takes quite a little time to develop the technique. The average man gets what Dr. Gant calls a doughnut, when he makes his first infiltration. I rather feel that what we are doing is blocking. I feel that we have to block the coccygeal nerves and then we go on and get our surface infiltration, and we can do almost anything within the realm of our anesthesia. The local anesthetic develops a need on the part of the surgeon for very much more careful work than is done under general anesthesia. The patient is going to let you know very readily whether you hurt him. My assistant tells me that I make a mistake by asking them whether they haven't any pain. Very often you get a little beyond where you anticipate and it is a good idea not to promise too much.

In the hospital in Newark we do 500 proctologic operations a year, of which over 95 per cent. are under local anesthesia. The Whitehead operation is relegated along with the other operations of the middle-ages. We all have the opportunity of overcoming the very fine plastic work done by somebody using the Whitehead operation. I find the only way I can relieve them is to split the sphincter, an operation which Dr. Gant does. Usually the contraction is just an anal contraction. The question of incontinence is one that every general surgeon who tries to do this sort of work and considers it minor surgery finds to be one of the inevitable things which he must face. We find the reason they get it is because instead of using drainage they use packing. You don't get much hemorrhage in the ordinary anal operation. We do have a little skin bleeding, that pressure stops. In ulcerative colitis, I think it is probably much more common than is readily appreciated, and it is fundamentally to my mind due to (except in those rather rare cases in this part of the country, where we have the parasitic origin) a congenital anatomical deficiency. These people have a fundamentally relaxed abdominal wall; they have a congenital deficiency, and with the saccululation of the transverse colon and with any type of constant irritation, they gradually develop an inflammatory process, which, of course, as Dr. Gant has described, eventually becomes an ulcerative condition.

A few months ago we were called by one of our surgeons to give him the reason. After we saw the case of appendicostomy done by the Gant method, not operated, Dr. Gant suggested the reason for it a little while ago. They cut off too much of the blood supply and get a necrosis, or they bring up their appendix and cecum too close to the bowel, and get it mixed up with the skin, and they get a stricture. The most satisfactory method for the general surgeon, to my mind, is the cecostomy, because he can do something with the bowel and can take the appendix out at the same time. It is hardly fair to leave a stump there and sometimes have to go after it. I find in the majority of these cases that even after they are cured by through and through washing it is necessary to treat the postural difficulty with some sort of abdominal support. Possibly the most distressing minor condition that a patient can suffer from is the little fissure in ano. I have had any number of cases that have been referred to me by neurologists; people have been treated for neurasthenia, for the usual gastro-intestinal disturbances associated with it, for years, until finally the doctor finds that they complain of some rectal symptoms, and if it is an old, chronic fissure, it can practically be operated with local anesthesia in our offices; but wherever we can do it, we do it at home, because I find that all of this office practice that Dr. Gant talks about is not very good policy. People don't like to feel that you claim they have to be operated upon and you charge them an operative fee, and then let them go out of the office. They like to feel that they have been patients in the hospital. For that reason I like to take them to the hospital and keep them there overnight, anyway.

I find that in rectal surgery, and in anal surgery particularly, 90 per cent. of your actual results are dependent upon proper aftercare. I dare say most any man can develop the technique in a little while to do the average work in this region, but the aftercare is something which comes with experience, and in the majority of these instances, as I said a while ago, drainage instead of packing; the idea of having the wound heal on John Hunter's old ideas of secondary union, you can't get any primary union, but granulate from the bottom of the wound, and you will never get into any trouble. I feel that we have been very much complimented by having Dr. Gant spend all this time down here and get acquainted with our ladies and then to give us this very excellent talk. I hope we will hear him very often in the future. (Applause.)

Dr. Berth S. Pollak, Secaucus: Mr. President, realizing that this is a surgical discussion, I desire to ask the doctor whether he has had in his large experience any experiences with the medical treatment of tuberculous colitis; that is to say, in our service, and I presume that we have had over 500 cases of tuberculous colitis in fifteen or sixteen years; we have been very unsuccessful from a medical point of view, but within the last two or three years, particularly since last year, my assistant has very carefully used the

calcium chloride treatment; that is, the injection of a 5 per cent. solution of calcium chloride for diarrheas and tuberculous colitis, and recently I can recall some six or seven cases where we have obtained most splendid results from the use of this treatment? Inasmuch as the doctor did discuss medical topics at the beginning of his discourse, I feel that I am not transgressing upon the field, even though I inject a medical thought into a surgical oration. There is just one other thought that has occurred to me. In our tuberculous work we necessarily find and see a great many cases of tuberculous fistulas. We have, from time to time, referred these cases to surgeons, and invariably we have been informed that we, of course, understand that general anesthesia would not be indicated in a case of tuberculosis of the lung, but we have thought that it was possible to do some good in these cases of tuberculous fistulas. Dr. Lippincott has spoken of one that has been successfully operated on. I might say that in my experience, not as a surgeon, but as a medical man, referring these cases to the surgeon, these tuberculous fistulas have not done well. I would like to have the doctor, in closing this paper, advise me concerning his opinion.

Dr. Underwood: We have heard two papers, and in one paper we were told that 9 per cent. of fistulas were tuberculous and in another, less than 5 per cent. of fistulas were tuberculous. I would like to ask Dr. Gant to give us his opinion on that subject.

Dr. Pollak: Mr. President, might I correct the doctor, because I made the statement? Dr. Newcomb, in discussing the question of tuberculosis, said that wherever fistulas were found, that they were usually tuberculous, and in my discussion of his paper I said that I was of the same opinion until more recently, when Lynch spoke before the Hudson County Medical Society, and upon inquiry he advised me that but 5 per cent., in his experience, of the fistulas that he saw, were tuberculous.

Dr. Charles B. Kelley, Jersey City: Mr. President, I could make absolutely no attempt to discuss Dr. Gant's paper, but I am glad to avail myself of the opportunity of asking a question. Dr. Gant's talk brought out, in my mind, a young lady on whom I operated about six months ago, doing a colostomy for colitis. I have irrigated her since with saline solution and ichthyol, and was quite persistent in the treatment, and while she has picked up, still she is expelling a great many casts, and within the last month I have been using an instillation through the colostomy wound of bacillus acidophilus. I would like to ask for an expression from Dr. Gant as to what he thinks of that?

Dr. Gant—Closing: I don't know that I remember all of these questions, but the subject of tuberculosis is particularly interesting. Regarding the ulcerative colitis, I think very few cases are tuberculous. When you get a tubercular colitis, your patient has already had a tuberculosis of the lung, he has had hemorrhages, and he is very much depleted; so results are very bad. I published a book

in 1896, and in that book I took the position that less than 5 per cent. of fistulas were tubercular, and when you get a tubercular fistula it has been preceded in practically all cases by a localized tuberculosis. What you do with the fistula does not depend upon whether it is tubercular or not; it depends entirely upon the vitality of the patient. If you have a patient with any vitality, you operate upon the fistula. If your patient is going to die of his lung trouble independently, in six or eight weeks, you probably hasten the result.

Most doctors operate, as you know, under general anesthesia. A great many books on surgery and medicine dating pretty far back tell us not to operate on a tubercular fistula. It wasn't the tubercular fistula that killed the patient, it was the surgeon. The ether will make a tubercular fistula active, if it is inactive. That patient should not have ether; he should not be confined in the hospital, at the most, more than one day. I do not know whether you have noticed the difference between ordinary fistula and tubercular fistula. There is no resemblance whatever between an ordinary fistula and a tubercular fistula. In an ordinary fistula, you have a small, little opening, round, punched out, and with a tubercular fistula you have a large, irregular, triangular opening, with blue skin dropping down into it and all undermined. Instead of having to probe for an opening, you can throw your probe through an outer opening. It is a cinch to operate all those cases under local anesthesia and keep the patient in the hospital for one night to see whether he has any bleeding or not.

Regarding the office cases that I spoke of, those were cases of thrombonic hemorrhitis; but I keep the patients for hemorrhoids, fissure and minor operations for three days; in other words, I want to know whether they are going to have a hemorrhage or not. It is a good idea to keep them in the hospital for one night, for the majority of minor operations, and even extensive fistula cases, where you do a lot of cutting, should not be kept there more than a week or ten days; let the patient go home, where he is very much happier, if you see that patient every few days and dress the wound. After you have operated for a fistula, if you run your finger down, like that, and it is smooth, all right. They have a wound that comes down here, and it is deeper inside the rectum than outside of the rectum.

In any operation, I don't care what I am operating for, I always cut the sphincter muscle, first, because I have no fear of incontinence. Secondly, if I cut below the sphincter muscle, there is no danger of infection. About the colitis, if you get a tubercular colitis, they are always difficult to handle, for the reason that, as a rule, that patient's lungs have been destroyed and he has swallowed the tubercle bacilli; they are put out of business for a short time during the passing through the stomach; they reach the cecum and 80 per cent. of all intestinal tuberculosis is found in the intestine. Then, if you have a case of colitis with tuberculosis of the lung, the thing to do is to do an appendicostomy or a cecostomy, under local

anesthesia; get him up to the mountains and do the ordinary irrigation and give him the ordinary diet, and your patient will do well.

If the doctor finds any kind of ulceration or any kind of symptom, he should not tell a man he has syphilis. Also if the man has a bad condition in the rectum, the doctor tells him he has tuberculosis. The fact is that tubercular colon is extremely rare. Tubercular colitis is the form in which you get the least results from an appendicostomy and a cecostomy. Sometimes you can cure amucous colitis—and in speaking of a mucous colitis I call it a myxorrhœa; that is, a mucous discharge. Where you have the discharge of mucus, that is a myxorrhœa or mucous colitis, if you prefer. When they get to having colic from it, you call it mucosa colica. In one you have the inflammation, and when they get the colic from that it is due to the fact that a lot of mucus is secreted. What happens is this: Sometimes when you get a bad cold, your head is comfortable as long as your mucus is thin and you evacuate it. On the other hand, when it becomes thick, your muscles contract and you become very irritable and uncomfortable. The same thing happens in your bowel, namely, the muscle of the bowel contracts. Sometimes the mucus, if it extends all the way around, gives a perfect shape of the bowel evacuated. Some people think they have passed their bowel. About the medical treatment, I think in a case of ulcerative colitis it is invaluable, and I always work with the medical man. I have not tried this treatment, which the doctor referred to, but it seems to me certainly practical, and I should re-enforce the surgical treatment with this.

Regarding the acid bacillus, if I can irrigate my bowel, I don't care anything about it. I have often used the bacillus, both in the injections and frequently for a long time we used to use various size dosages of bacillus, putting it through the cecal opening or appendicital opening, and it didn't seem to make much difference in the cure. My own idea is that if you keep all of those mucous membranes clean and you feed the patient, he will come back quickly. In connection with the technique in the use of local anesthesia, I don't pay any attention to the blocking that the doctor mentions. I block just where I want to operate; that is where my distension comes in. If you commence to look for a nerve around the periorectal region it will take you ten times as long as to operate on the patient. On the other hand, if you don't, most of the operations, from the time you start till the time you finish, will only take five or six minutes, and with the exception of one prick of the needle, you do it absolutely without any pain. Are there any other points? I want to thank you all again for inviting me to come down here. (Applause.)

Newark Department of Health.—The annual report for the year 1922 was received as the Journal for September was nearly ready for the press. It shows an unusual amount of work done with remarkably good results. The death rate for 1922 having been 12.1, its second lowest on record, and the twenty-fourth lowest among the 62 cities of the United States having populations of 100,000.

THE DOCTOR

The President's Address, Delivered at the 157th Annual Session of the State Medical Association of Texas, on May 8, 1923.

By Joe Becton, M.D.,

Greenville, Texas.

After a few introductory remarks, Dr. Becton said:

Before I get into my subject, I want to quote from the presidential address of my lamented father, delivered thirty-seven years ago. He said: "Doctors are like other men; they have their high hopes and ambitious aspirations, and they feel keenly merit unappreciated, labor unrewarded, their field of action limited and for the most part hidden from the gaze of an admiring world." The sentiment expressed therein exists today; history is but repeating itself.

An address upon an occasion like this, in my opinion, should not be a scientific medical dissertation, which, because of its technicality, would be of little interest to many of you. There is much else that can and should be said that is of vital interest to the people as well as the medical profession. I am convinced that a more thorough knowledge on the part of the public of the relation that the medical man bears to the citizenship generally, would be of great value to the profession in the furtherance of its efforts to bring about a much needed medical and health legislation.

It is not so much how to cure disease as it is how to prevent it, that concerns us. Many do not understand our purpose, and the cause for which we labor is often misjudged on account of a lack of knowledge of the motive which prompts us. It is our purpose to give to the people doctors who are thoroughly trained, not only in the fundamentals that underlie our profession, but the allied sciences that are germane to it, and to secure public health laws and sanitary regulations that will protect the people from disease.

Friends, the medical profession from the time of Hippocrates (the Father of Medicine), 600 years before Christ, have spent their time, talent, energies and oft-times their lives, for the health, happiness and life of the human race; and it is with no little degree of pride that I say that the glitter of the shining shekel, or the plaudits of men for a day, has been no incentive. Its one mission is and ever

has been to make the world a better, healthier and happier place to live in. It needs no law for itself. Its life is one of consecration to duty, and that duty is to help the human race.

Governments have in the past enacted very few laws for the protection of health. Our profession has had to fight, and fight hard, for every such law on the statute books. Men will legislate concerning gold or grain, commerce or cattle, swine or wine, but for the health of its people—that's left for "the doctors to fight over." Can we feel encouraged to do our civic duty when maledictions and anathemas are hurled at us because of our activities? If it were not for a feeling something like our Savior must have had when He said, "Father, forgive them, they know not what they do," we would give up the ship and let the public drift back into that ignorance and superstition from which we have led them.

A brief retrospect, if you please; what the physician has done for mankind:

In the sixteenth century the average human life was 26 years. Up to the middle of the eighteenth century it was 32 years, and now, I am told by statisticians, it is past 50.

Did you ever stop to think who builded the Panama Canal and mingled the waters of the Occident with the Orient? France with her millions of money, her many statesmen with colossal minds, and her people of indomitable will and perseverance, got no further than to demonstrate that the gigantic project had to be abandoned. Why? Because it became a veritable gehenna. Men died by the thousands. The project was perforce abandoned, until the fertile brain of an American physician, General Gorgas, with his knowledge of disease and how to combat it, of sanitation and how to handle it, brought about the chameleon change, made order out of chaos and finally made the place a "health resort," as it were. If all the brains, intellect and nerve energy of all the chiropractors and christian scientists that ever lived or ever will live, were put into one individual and he could live a thousand years and work ten hours a day, in the end his achievements and his results would compare like a mere streamlet trickling down some lonely dell, with the great Niagara that spills its millions of tons of water into the lakes. And this man was a doctor.

Who gave to the world the knowledge that the deadly yellow fever, that at one time almost depopulated our tropical and semi-tropical countries, is spread by the mosquito, and in so doing made the supreme sacrifice? A doctor!

Who discovered that malaria is not a noxious miasmatic disease, thought to exist in the air, but a disease transmitted to man by the female mosquito? A doctor!

Who robbed that loathsome disease, smallpox, that leaves the mark of Cain, as it were, upon its victim, of its awful hideousness, stopped its walk of pestilence and all but confined it to the individual? A doctor!

Who demonstrated to mankind that the death-dealing bubonic plague is due to a micro-organism conveyed by fleas, from rats to man? A doctor.

Who told us that diphtheria had been robbed of its terror and its destructive power impeded by an antitoxin, that in a few hours neutralizes its poison? A doctor!

Leprosy—the disease that alienates its victims from humanity and makes them loathsome wanderers. Who now sends a ray of hope to their benighted lives? The doctor!

Who discovered the tubercle bacillus the ghost of the great white plague, that tortures its victims for months or years before the lethal night comes? A doctor!

Who differentiated and catalogued cancer, and laid down rules for early and successful treatment? The doctor!

Who digged up pericolic membranes, diverticulums, intussusceptions, flexions and versions in the human body? The doctor!

Who gave to suffering humanity chloroform, ether and nitrous oxide; who made it possible to administer under the skin and around the nerve, or in the spinal canal, a local anesthetic that would take from surgery its pain, and yet allow the patient to retain consciousness? A doctor!

At last but not least, who found appendicitis? My God, a doctor, not a chiropractor or a christian scientist!

Friends, these are noncontrovertible facts, not theories, that will stand as Gibraltar before the onslaught of ignorance and quackery, charlatanism and misguided creeds and dogmas, as long as the mind has reason and conscience has judgment. God pity the fiend in human form

who attempts to take advantage of the unthinking public, and prey upon their credulity; who makes the unholy claim that the honest, God-fearing medical man is but a merchant with wares to sell.

Let's be honest with ourselves, Shakespeare says:

"To thine own self be true,
And it needs must follow as the night the day,
Thou cannot be false to any man."

Let's contrast—study facts for a while: The medical training required of all medical schools by the Council of Medical Education and Hospitals of the American Medical Association, is a pre-medical course of two years, after high school or college work, or better than four years of nine months each, and one year's internship in a well-appointed, recognized hospital. After this comes the State Board of Medical Examiners (and I am happy to say that Texas has an exceptionally good one), before a graduate can ever offer to practice medicine.

The chiropractor—let's see. If the chiropractors have a scientific, recognized college, that pretends to give a thorough medical training, I never heard of it. I do know that they are trying to get a law passed by the Legislature to exempt them from the Medical Practice Act and give them a separate board. The bill referred to recites: "Any person shall be regarded as practicing chiropractic, within the meaning of this act, who shall publicly or privately represent himself to be a chiropractor."

No instance can be cited where a chiropractor ever gave any study to the fundamentals of medicine; to know the body in health, or to know or understand disease or its effects upon the various organs of the body. No; they want to tap the spine for all diseases from bald head to toe itch. Real health laws are to these people fantastic myth, and sanitation an enigma—an unknown quality. They never gave to the world a single important fact. They have never by any discovery—in science or sanitation prolonged the human life one hour. They do not nor have they held a single place of trust or responsibility in civic or military government. How long would you live in a city where the health officer was a chiropractor and the food inspector a christian scientist? These people are but amoebae and parasites on humanity—their only specialties are Gullology, Spinology and Dollarology.

Friends, we are building character, consciously or unconsciously. Emerson said, "I am a part and parcel of all that I come in contact with," and Omar Khayyam wrote, truly and beautifully lines, in the twelfth century:

"The moving finger writes; and having writ,
Moves on: Nor all your pity nor wit,
Shall lure it back to cancel half a line,
Nor all your tears wash out a word of it."

We cannot stand still. We find progress the handmaid of effort, climbing loftier altitudes and achieving greater possibilities. What we begin for ourselves, God finishes for others. Others begin where we leave off, and carry our work to a stage nearer perfection. We must bequeath to those who come after us a noble design, worthy of imitation. Well done, well doing and well to do, are inseparable conditions that reach through all the ages of eternity. We are working, building and writing for humanity of today and posterity of tomorrow.

There is no profession that has such a variety and intricacy of relations with the world outside itself, as the profession of medicine. The maintenance of these relations, between the practitioner and the patient, preserve the dignity of our calling and make it a benediction to the body and soul of man. We realize that the practice of medicine and surgery is a public trust, and unless we keep step with the colossal strides that science is making day by day; unless we are students and keen observers of technique, are microscopical and pathological researchers and listen to the oracle speaking from the sanctuary of healing, we are betrayers of that trust. May God forbid that such shall ever be the case. Ignorance is pitiful at all times, but it is criminal when it toys with human life and happiness.

Spiritually, the doctor is often the father confessor of the family and it is his duty to lend a ready ear and, mark you, to forever keep inviolate the confidence thus reposed; as Oliver Wendell Holmes says, "He shall keep as silent as the woman who wore the scarlet letter in the market place." The intimacy, the delicacy of relationship sustained by the physician to the laity, requires him to be, or try to be, pure in heart; for him no boudoir holds a Magdalene or Jezebel. Think, my friends, of the majesty of a profession which has a standard like that.

We know what it means to maintain

calmness in the presence of a frightened patient and family. It has saved many a life, averted many a tragedy. Macbeth's question to the doctor, "Canst thou not minister to a mind diseased?" means more than poetic rhythm. Even the surgeon, accustomed to the proofs of material evidence, cannot entirely overlook the psychic side of things; we must and do consider the influence of the mind on the body and our mind on other minds about us. Therefore, it is more than a point of ethics, when I say that we should bring a cheerful word and a hopeful face into the sick room.

If the doctor is not constitutionally a humanitarian, his calling forces him to be one. His peculiar relationship to his people means charity in a sense almost compulsory. For, when God's poor are to be served, the consecrated physician willingly faces the elements and all dangers, at the risk of his own health, yea, even his life.

Let us consider what the laity owes us. The moral obligation is, or should be, to help us—help us to get good, wholesome laws that will protect the people from ignorance, quackery and the cults; to demand that physicians be trained, and that they at least be as competent to diagnose disease as the lawyer is to write a deed to a hundred-dollar lot. It would seem, in many instances, that the laity wish the doctors, as they would wish a statue, as an ornamental figure. How can the physician get results when the rules of procedure are openly and secretly violated? Unless we can have and retain the child-like confidence, our work is robbed of half of its usefulness.

Another common error is the thought that the doctor is devoid of sympathy, because he does not wear his heart upon his sleeve. Picture, if you can, a diphtheritic child struggling, clutching and fighting for a breath of air; it suffers cruelly, while the anxious parents bend over in an agony of hope and fear; the pangs of pain sink into their very souls, like darts of steel; their only hope is the "doctor," and I speak a genuine truth when I say that he who in that hour stands in the Garden of Gethsemane is he who holds the gray wolf of death at bay. So, friends, accord to us the virtue of sympathy, quickened, not blunted by experience; guided, not strangled by self-control.

But the most agonizing—the most crucial hour that comes to the doctor, is when he must stand helplessly upon the shores of disappointment and see the frail bark which he has tried to keep in port, loose its moorings and drift, drift out upon a shoreless sea, while lingering love mournfully cries its piteous farewell. You do not—you cannot know how the doctor suffers; you cannot see the anguish of his heart; a human life entrusted to his care and keeping is lost to this, our mortal world.

In spite of the trials, the profession has its compensation—has it in the triumph of science over superstition; has it in the sacred feeling that it is ministering to those whom He made in His own image, and, last but not least, has it in the gratitude of that mother when she looks into the baby blue eyes of her first born, and sees the rose of health returning to the wasted cheek, and the look of peace that gradually steals in on the face of pain.

The doctor is adviser, friend and physician, and to him, in times of perilous disease, when the tempest-tossed bark of life is being dashed from crest to trough by the turbulent waves of pain, he seems the only mariner who can guide us safely and smoothly into a port of sweet tranquility. He comes not like the plumed knight or the gilded warrior; his mission is not amidst the sound of trumpets or shouts of men, or the rattle of shot or shell, to rush into a vortex of carnage and death, but like a ministering angel softly, gently, he soothes the aching, quiets the delirium, fights back the grim monster of death and lets in the sunshine of life. No cold, cruel hand of ambition pushed you from his heart; he does not want to climb the ladder of fame and place his star in the galaxy of success though death, devastation and ruin to his fellow man. No, thank God, he presses forward to lift the fallen, cheer the dejected and cast the mantle of charity over the shortcomings of humanity. Like the meek and lowly Nazarene, the blessed God, he says, "Go thy way and sin no more."

We see him when the curtains of night are drawn, and the cloak of darkness is spread over the sleeping and dreaming world, sitting by the couch of some poor sufferer—it may be a stranger in a strange land, far from home, far from sister's

care and a mother's love, whose suffering and agonies he endeavors to alleviate. It may be some brave and darling boy who has sacrificed his life upon his country's altar, and falls bleeding and torn, beneath the shadow of her flag, with only the patient doctor to receive his farewell message, e'er that noble soul marches beyond the breastworks that divide him and eternity. It may be a hoary-haired patriarch, who is only waiting for the Divine call to come and receive his "well done, thou good and faithful servant, enter into the joy of thy Master," or it may be some poor, lonely, heartbroken mother that the doctor and the angels are keeping vigil with, over the couch of her wasted and emaciated child, with parched lips and anxious countenance, with brow bedecked with the cold and clammy sweat of death, its little voice so faint and far away that the watchers have to hold their breath to listen for the last sweet, sad, lingering accents.

There are many doctors here who have heard some little one say: "Don't cry, mamma, I'll be better tomorrow," and close its lovely little eyes to awake beyond the stars, for the flower has been transplanted in the Garden of God, where the night of death never comes. There is no higher calling; there is no life so self-sacrificing, there is no one who gives his all to his fellow man, as does the doctor. He is the same, yesterday, today and will be forever more.

In the even tenor of his way, he goes from the squalid hovel, where poverty nurses as a child and misery lends a helping hand, to the splendid palace, where opulence is a burden and lucre is a plaything. The same gentle demeanor characterizes him at all times and none but his co-laborer, the minister, knows how the world lives from the cradle to the grave.

The one fact of which I am the proudest of all, is that God never made a coward and a true doctor in the same man. There is no record in present or past history where any people, of any nation, clime or country, where disease, plague or pestilence stalked by day and night, claiming its victims by the tens of thousands, but some good doctor went fighting, fighting, until perhaps like our own brave Dr. Manning, of Austin, in 1878, went to Molly Springs, Miss., during the yellow fever scourge, and remained at

his post of duty until that bright life, from exposure and self-denial, like an untended flower, withered, drooped and died. Such acts will not soon fade from the memory of men. That star shed a lustre that will forever shine through labyrinth of years, until methinks the reflection shall be caught and cast upon the throne of God.

A CASE OF SITUS INVERSUS

By **Frederick H. von Hofe, M.D.,** and
Carlo D. Martinetti, M.D.,

Orange, N. J.

The following case was thought worthy of consideration, because of its relatively infrequent occurrence, and furthermore, because of the very early age at which it was detected. As far as we can learn, it is the youngest case reported in the medical literature.

J. S., white male, age six weeks, reported to the out-patient department, with a history of cough for the past week. He represents the mother's second pregnancy. The birth was normal, with a vertex presentation. The birth weight was nine pounds eight ounces. The infant was nursed to date. The father's age is twenty-nine, and the mother's age is twenty-eight. Physical examinations reveal no abnormalities in either parent. The first-born, a female, five years of age, is living and well, but is not available for examination.

Physical examination: A normal appearing white male infant is well-developed and well-nourished. The weight is eleven pounds three ounces, the height twenty-four inches, the circumference of the head seventeen inches and the circumference of the chest sixteen inches.

Head: Normal contour. The fontanel admits the tips of two fingers. The eyes, nose, external ears, mouth and throat appear normal. There are no teeth erupted.

Chest: Well-developed. The apex beat is in the right nipple line in the fifth interspace. The apex beat is heard best in this same area. The heart sounds are normal. The lungs are clear throughout.

Abdomen: Soft. The umbilicus appears normal. There is a mass on the left side, which extends three-quarters of an inch below the left costal margin, which is apparently the liver. The spleen is not palpable.

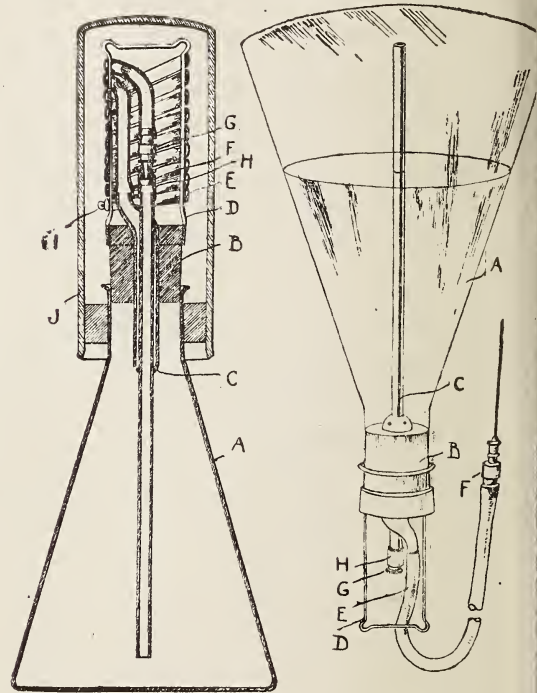
Extremities: Normal. **Genitals:** Normal. **Skin:** Normal.

NEW APPARATUS FOR THE ADMINISTRATION OF FLUIDS

Dr. Edward F. Lane

Medical Director of the Department of Pathology and Experimental Medicine,
Middlesex General Hospital, New Brunswick, N. J.

This apparatus has been designed with a view to providing a safe, easy method for the intravenous, intramuscular, intraperitoneal and subcutaneous administration of fluids—saline, glucose and sodium bicarbonate solutions. It is simple and at the same time surpasses in asepsis, convenience and adaptability any apparatus at present in common use.



The instrument consists of a flask (a) of any desired capacity, though I have found that one of 500 c.c. is the most suitable for general use, with the highest graduation at the top, provided with a rubber stopper with a single hole (b) through which passes a glass tube (c) so constructed that it at the same time empties the flask and admits the air necessary to empty the flask. Attached to the rubber stopper is a framework (d) of German silver, on which the rubber tubing (e), of sufficient length to allow a good head of pressure, is conveniently wound. The apparatus, when packed, is self-sealing by means of two adapters, one of which (f) is attached to the rubber tubing, and so provides a quick, sure attachment for the needle and the other (g) is attached to the second outlet of the glass tubing by means of a rubber connection (h) to give pliability and so prevent breakage. The adapter f is slipped into the adapter g, and the rubber tubing wound around the frame and fastened by means of the lug (i) provided. A glass cover (j) fits over the top of the flask enclosing the

ubber tubing, framework, stopper and adapters, so that no dust or organisms can enter.

To prepare the apparatus for use, it should be filled, sealed and sterilized in an autoclave, and is then ready for use. It can be easily carried in the physician's bag or placed in a convenient place in the operating room.

In the physician's bag there is no danger of leakage when the flask is placed on its side, provided the stopper and adapters have been securely placed.

The preparation of sodium bicarbonate solution is somewhat different from other solutions, because of the fact that it is broken down by the heat in autoclaving. In the preparation of it, after autoclaving, carbon dioxide bubbled through the solution for several minutes to replace that which was lost. The adapter is cleansed with alcohol and the flask is sealed again for future use.

Miscellaneous Items

Dr. Arthur W. Belting, Trenton, has been appointed by the Governor an additional member of the State Medical Advisory Board.

Canada is to give Dr. F. G. Bunting, discoverer of the insulin treatment for diabetes, an annuity of \$7,500. Thus a very able scientist will be enabled to devote his life to medical research. It is in marked contrast to the usual way in which America and Great Britain have treated their medical pathfinders, and indicates a desirable advance.

New Jersey's Physicians and Hospitals.—According to the A. M. A. Jour., New Jersey has in 1923, 3,362 physicians—a gain of 102 since 1921; also 154 hospitals. We certainly ought to add 1,000 members to our State Medical Society.

Illegal Practitioners Fined.—Salvator Spinelli, Rahway, was arrested in March, 1923, on a second charge of practicing medicine without a license, and when the case came to trial, June 26, pleaded guilty and paid the penalty. Spinelli had been found guilty of a similar charge in December, 1920.

Charles Baudendistel, West New York, N. J., a licensed osteopath, was arrested on a charge of practicing medicine without a license. He pleaded guilty and was fined \$200, July 5.

Triplets Twice in One Hundred Years.—Triplets were born at the New York Nursery and Child's Hospital, July 25. The institution had operated ninety-nine years before such an event occurred. The first triplets born in the institution arrived last February.

Lived Five Hours After Breathing Ceased.—An extraordinary case of a man whose heart went on beating for five hours after he had ceased to breathe, was reported in a recent issue of the Manchester (England) Guardian. The case was that of Norman Lees, a young clerk, who was admitted to the Manchester Royal Infirmary on November 30 last, suffering from a cerebral abscess. He had been in the institution for several months, when one

day the nurse noted a considerable change in his condition. He collapsed and his breathing had apparently stopped, but his heart was still beating. The doctor in charge came at once in answer to her summons, and artificial respiration was resorted to. After some minutes' work, breathing was again audible and continued for a little time after the artificial efforts had ceased. Breathing then ceased again and artificial respiration, oxygen, drugs and other methods were tried, with the result that breathing again started and continued for a few minutes. A third attempt brought less results and the breathing finally ceased at 5 o'clock. For four hours afterwards, two doctors, three or four nurses and one of the attendants went on with the work of trying to restore the breathing, but failed to obtain any signs of life beyond the faint beating of the pulse and the heart. The pulse first ceased to beat. About 8:30, the heart beats became gradually more and more indistinct and they finally ceased at 9 o'clock.

The Manchester medical authorities believe the case is unprecedented in the annals of medical science. There have been instances in cases of cerebral disease where the action of the heart has continued for some minutes after breathing has stopped, but they claim that there have been no authenticated instance in recent years where the heart has continued to beat for nearly five hours.—Critic and Guide.

On Drinking Hot Water

Many know but few think of drinking hot water, which is a very important factor in the improvement of health and the prevention of disease.

It dissolves and removes from the body waste matter of all kinds, the retention of which would be liable to set up chronic rheumatic and gouty conditions.

It would be well to take one pint and a half two hours before breakfast, and another pint one hour before dinner and supper.

It is an advantage if a little alkali, say, bicarbonate of soda, and perhaps a little common salt, be added to the water, because most of the waste matters are acid, and the addition of the alkali assists in their solution.

On Worry

The etymology of the word worry presents a whole series of valuable reflections on the process. There is nothing like getting the original meaning of a word to enable us to understand its real significance.

Worry is a good illustration of this:

It comes from an old Saxon root "wurgan," which means to strangle, to suffocate.

Worry literally chokes effort. Very often it is accompanied physically by a senses of tightness in the throat. When we talk about a dog "worrying sheep" we mean that he is grabbing at their throats and pulling them down. That is one of the oldest uses of the word and represents just what the word has always essentially meant. No wonder that Shakespeare spoke of worry as "A hell hound that doth hunt us all to death." (From Dr. James J. Walsh: "Success in a New Era.")

Insulin Treatment for Diabetes.—By providing special funds for the support of insulin treatment for diabetics in the United States and Canada, the younger Rockefeller has taken one more step in his especial field of philanthropy, the wider extension of the benefits of modern medicine.

That, however, is but incidental to the fact that the \$150,000 which he has made available to fifteen hospitals, in sums of \$10,000 each, will bring the benefits to the less well circumstanced financially among a large class of particularly appealing sufferers. * * * Mr. Rockefeller's gift, part of which is made available to New Jersey sufferers through the Physiatrie Institute at Morristown, will do two things, as it is outlined. First it will make the new treatment available to those who could not afford to seek it on an unaided financial basis, and these are not few among diabetes victims, for this is a disease which quickly destroys activity and earning power. Second, it will enable physicians to be schooled in the use of the materials, which requires some experience under expert instruction. Dr. Simon Flexner of the Rockefeller Institute, through whom Mr. Rockefeller makes his gift available, unqualified indorsement of insulin and the claims made for it carry due weight with unprejudiced.—From Newark Evening News.

Medical Education—Progress of Twenty-three Years

This week, for the twenty-third consecutive year, The Journal publishes statistics regarding medical education in the United States. During these years, medical education in this country has undergone extensive improvements, and educational standards have been brought to a reasonable high plane. * * * * *

Summary of Progress Made: During the twenty-three years, medical education has been greatly improved and educational standards are now on a par with those of other leading nations. A large oversupply of medical schools, including many low type institutions, have given way to a more normal supply, of which it is definitely known that all but six of Class C require for admission two or more years of college work. But many other improvements have been made: Endowments have been increased; new and larger medical buildings have been erected, and, in a score or more, entirely new teaching plants constructed; more and better equipped laboratories have been established; better hospital relations have been secured—several colleges having built hospitals of their own—and better teaching methods have been adopted. The number of students was reduced from 28,142 to 13,052⁸ in 1919; the proportion of medical students in well equipped medical colleges was increased from 3.9 per cent. to 87.9 per cent. Since 1919, the number of students has increased to 17,432, of whom 94 per cent. are in Class A colleges. Of medical graduates, likewise, although the total has been reduced by 40 per cent., the number coming from high grade, well equipped medical colleges has been increased from 5.6 per cent. to 92 per cent. The number of graduates this year shows an increase of 591 over last year, when the smallest number graduated. Indications are that the

next few years will show a steady increase, and that a still larger percentage will be from Class A medical schools.

The progress made in the improvement of medical education has been much more rapid, and fewer difficulties have been experienced than were anticipated at the beginning of the campaign. This was due largely to the cordial and ready co-operation received from the officers of medical colleges and state licensing boards, both individually and in their national organizations. The publicity secured by the report to the Carnegie Foundation for the Advancement of Teaching was a great help in the campaign, particularly in calling the attention of philanthropists to the financial needs of medical schools. The end sought has been attained, and medical education in the United States is now equal to, if it does not surpass, that in any other country.—From the A. M. A. S. editorial.

Medical Society Meetings.

Conference of Secretaries of State Societies

An annual conference of Secretaries of Constituent State Medical Societies will be held at the A. M. A. offices in Chicago on November 16 and 17. A program is being arranged for a meeting of Editors of State Journals on the evening of Friday, November 17th.

American Medical Editors' Association

This Association will meet in Chicago on October 25 and 26. An unusually full program has been provided and the Secretary says it will be "one of the best ever held."

Tri-State District Medical Association.

The Annual Meeting of this Association will be held in Des Moines, Iowa, October 29 to November 1. This association is a purely post-graduate organization. The entire time of the annual meeting is taken up with scientific study. Several of the most eminent members of the profession in this country and Canada have accepted places in the program. The indications are that it will be the largest, most interesting and instructive meeting the association has ever held. New Jersey physicians are invited to attend. The headquarters are Fort Des Moines Hotel, Managing Director, Dr. W. B. Peck, Freeport, Ill.

American Roentgen Society

The twenty-third annual meeting of this Society will be held in Congress Hotel, Chicago, Ill., September 18-21, 1923. An excellent program has been arranged and among the distinguished contributors will be the following from foreign countries: Drs. Robert Knox, England; W. Friedrich and Gustav Bucky, Germany; Paul C. Hodges, China, and Carlos Heuser, Argentina.

Precocious.—The Riches are each twenty-eight years old. They were married in February, 1921, and the baby boy born six weeks ago was their first. He is an accountant for the Underwood Typewriter Company.—From a news item in the New York World.

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OF THE

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Each member of the State Society is entitled to receive a copy of the JOURNAL every month. Any member failing to receive the paper will confer a favor by notifying the Publication Committee of the fact.

NOTE.—The transaction of business will be expedited, and prompt attention secured if,—

All papers, news items, reports for publication and any matters of medical or scientific interest, are sent direct to THE EDITOR, New Brunswick.

The County Society Secretary shall send promptly to Dr. Morrison, Secretary of the State Society, notice of the election of every new member, with his address; also of any changes of members' addresses.

All communications relating to reprints, subscriptions, extra copies of the JOURNAL, books for review, advertisements, or any matter pertaining to the business management of the JOURNAL are sent direct to THE CHAIRMAN OF THE PUBLICATION COMMITTEE, Newark.

A Practical Suggestion.—The following appeared on the front page of the London Times of July 23, 1923:

Don't forget to pay your doctor before you go on your holiday. He may want a holiday too.—G. P. Sufferer."

PLEASE READ CAREFULLY

Most of the officers and members of our Society have returned from their vacation trips and have resumed practice. As we begin the Fall and Winter work of our State and County Societies, we emphasize the importance of the careful observation of the following as essential needs for the successful prosecution of our work and for the advancement of our Society's and the public's welfare:

All communications should be addressed to the Officers and to the Editor as specified above under the word NOTE.

All records of County or Local Medical Society meetings should be sent to the Editor as soon as possible after each meeting is held, and early notice of the death of any member and important personal notes concerning members. These to be sent either by the Secretary or Reporter as their by-laws require. In the past several deaths were not reported in the Journal until weeks after deaths occurred. Corres-

pondence on important professional subjects is also solicited.

The accurate name and address of every newly-elected member of each County Society, as well as changes of residence should be reported as soon as possible to the Secretary of the State Society, Dr. Morrison, and the State Society dues should be promptly collected and forwarded by the County Society treasurer to the treasurer of the State Society, Dr. Marsh, immediately. Delay in sending these names and dues prevents the newly-elected member from receiving the Journal, from receiving medical defense protection, if needed, and from recognition by and enrollment in the American Medical Association as a regularly qualified practitioner of medicine.

Our members will also carefully note what communications are to be sent to the Chairman of our Publication Committee. It should be understood that all monies paid for reprints go to the company that prints our Journal, the Society receives none of it.

THIS MONTH'S JOURNAL

We regard this month's Journal as one of the most interesting and valuable we have ever issued. The orations of Drs. Pollak and Gant are of a high order of excellence. The presidential address of Dr. Becton, of the Texas Medical Society, which we found in the Texas Journal, so favorably impressed us that we inserted it, as worthy of our members careful consideration; it should be inserted, if possible, in the leading newspapers of our State to educate the public concerning the doctor's position and the profession's relations to the public, as the Illinois Medical Society is now educating the citizens of that State by similar articles in the newspapers of that State. We also call special attention to the editorial, "The Doctor's Reputation," and to the reports of Dr. Eagleton, of the Welfare Committee, and Dr. Beling on "Medical Defence and Industrial Insurance," which should be carefully studied in order that our members may be early informed concerning present conditions and be prepared for the fall and winter's work in these important departments of our Society's activities.

Our profession's, and our Society's greatest needs are that our members shall give careful thinking, wise planning based on accurate knowledge and prompt, decided and united action on these matters. That will mean our individual members and greater

professional standing and prosperity and our Society's and the public's highest welfare.

THE DOCTOR'S REPUTATION

We are indebted to Dr. J. S. Yates, of Paterson, for the following items taken from the Passaic Daily News, which are worthy of our members careful reading and heartiest commendation. We believe we are justified in speaking for all the members of our State Society in expressing deepest appreciation and sincere thanks to the Daily News for the just and honorable position taken in guarding physicians' reputations against unjustified suits brought by ignorant or designing persons. The first item is as follows, August 1st.

Why this story is not printed.

Professional Reputation, Hard to Build Up,
Is Easily Destroyed.

Papers were filed today in a suit for \$25,000 brought against a reputable dentist in which it is alleged that a patient died due to an overdose of cocaine.

In accordance with its policy, the names are not printed in The Daily News. It requires a life time to build up and cherish a fine professional reputation—but a moment to destroy it.

The Daily News believes that professional people should be protected against the damage done by strike suits, and that in the case of bona-fide actions it is time enough to print the facts about them when the case comes to trial.

Of the merits of the present case The Daily News knows nothing.

The second item is an editorial, August 2nd:

Why Ruin Them?

So far as it knows, The Daily News is the first newspaper to take the flat position that it will not print the "news" of the mere filing of papers commencing suit for damages against a professional man or woman engaged in the practice of medicine or dentistry.

Whether this rule can properly be extended further into the professions is a doubtful question. But The Daily News has had occasion to note several perfectly unjustified suits against physicians, and it has dawned upon it how an honorable reputation of a lifetime might be swept away in a moment for no good reason whatever. At least one of the suits was a strike suit, pure and simple, and when it got into court it was proved to be so.

The filing of notice of suit and the issuing of summons does not necessarily mean that the professional person charged with malpractice is guilty of anything of the

kind. It is merely notice that at a later day the court is to be asked to pass upon the merits of the matter. Physicians and dentists, especially, are open to such suits on the part of ignorant or designing persons. It is only fair to admit that the vast majority of physicians and dentists are trying their level best to relieve distressed humanity. They are human, and they make mistakes, some of which are of course fatal. But their business, and their desire, is to serve, not to gouge, their fellow men.

When, through ignorance, or cupidity, or even justly, such a person is charged with malpractice, we prefer to give him his "day in court" before he is ruined.

There is no class of men more interested in, and greater contributors to the public's welfare, and our country's standing among the nations of the world than that composing the members of the medical profession. Therefore, as doctors, as well as citizens, we profoundly regret the death of President Harding. We believe he was one of the ablest and best Presidents we have had and that his sudden death was a great loss at this particular crisis in our nation's life. Our warmest sympathy is extended to his worthy and brave widow.

We call attention to the notice on page 314 of the Annual Meeting of the Tri-State District Medical Association of Iowa, Illinois, Wisconsin and Minnesota, to be held in Des Moines, Iowa, in October. An invitation from Managing Director Peck, says: "The physicians of New Jersey, who are in good standing in their State Society, are most cordially invited to attend and take part in the program."

We also call special attention to the communication from Dr. J. A. Spaulding of Portland, Me., and urge our members to send their protest to the Internal Revenue Department, Washington, as the Ruling does great injustice to the profession and the public.

DOCTORS PLANNING TO AGREE IN COURT.

From the Boston Med. & Surg. Journal.

This heading is used by the New York Times in reporting the action of the Medical Society of New Jersey in the formation of a committee with the object in view of working out a basis of standardization for injuries coming under the Workmen's Compensation Act. The explanation is

ound in the conflicting testimony sometimes offered in court relating to an estimate of the relative importance of a disabling injury. For example, the loss of an eye is rated by one physician as meaning diminution in earning capacity of 20 per cent. or normal efficiency, whereas another estimated the same disability up to the extent of 40 per cent.

The committee will draw up a schedule which will fix the per cent. of lost efficiency by reason of injuries covered by industrial insurance. Conflicting testimony has led to disrespect of medical opinions, and in order to establish a standardization of the extent of disability and medical testimony relating thereto, this plan will be of benefit to the injured employe and tend to promote the standing of medical testimony.

The heading might have been better, for without reading the context, a superficial observer might have inferred that this plan to agree in court would mean an effort to do away with independent opinions, or a scheme to unite the profession to the damage of persons affected by the testimony.

A similar plan might well be adopted by all the States. Will our Society follow the example set by the New Jersey State Medical Society?

REPORT OF THE WELFARE COMMITTEE.

Presented at the 157th annual meeting of the Medical Society at Atlantic City June 21, 1923.

By Wells P. Eagleton, M.D., Chairman

There are today many problems before the public of this state, in solving which the medical profession must play an important part. They are medical problems, and we alone—doctors—are competent to handle them scientifically, ethically, and equitably.

Taxation is increasing by leaps and bounds. It is chiefly for ever-increasing expenditures for education and for so-called welfare work.

Medicine in Relation to Education:—Educators are beginning to see the necessity for discrimination, not in the work itself but in the indiscriminate amount of education supplied at all alike, irrespective of their ability to utilize it. A considerable portion of our students in the common schools today are incapable of continuing work in their classes, at the prescribed rate, and some are simply being carried through their curriculum bodily.

Under the present law, schools are com-

pelled to retain students until the age of sixteen years, even when their mental capacity does not permit of their advancing. It is nothing unusual for them to stay in one grade for four or five terms.

The Carnegie Foundation in its report on the advancement of teaching last year, makes the following statement: "It is perfectly clear that if the demands of the schools continue to increase at the present rate, or, as seems more probable, at an increased rate, the financial inability of society to pay the cost will, in a measurable time, bring about radical curtailments. In no distant day we shall see, under these conditions, free public education endangered. Under the enormous load of taxation that society carries today, communities will rise against the burdensome cost of public school education."*

Add to this the medical aspect of the case; the mistraining or attempt to train, minds below the normal; the consequent delay to normal minds, and their possible corruption through association with inferiority; the numbers of unnamed progenitors of more greatly undeveloped minds annually maintained in and worried through our public schools, and the situation becomes menacing indeed.

Medical Aspects of Welfare Work:—Each year greater and greater appropriations are being asked to establish a new welfare work. All welfare work is almost entirely a medical problem, and its medical phases should be conducted by medical men. Mrs. McKim Garrison has recently stated that approximately forty per cent. of the state's money was expended on its dependent's. (Civic Pilot, June, 1923, p. 17.) In the case of the so-called wards of the state millions are being asked and expended, and ever more and more buildings are being called for. A recent authority has stated that we are creating an aristocracy of incompetents. While enormous sums for relief work are being annually expended, not one cent is being appropriated to prevent insanity by discovering the emotionally unfit in the schools or by sterilization to prevent of the feeble-minded or insane. There has been no law enacted to prevent the coming generation from being burdened with as many feeble-minded or insane as the present.

*Carnegie Foundation for Advancement of Teaching. 17th Annual Report, 1922, p. 116.

Insanity and feeble-mindedness are on the increase. The National Committee for Mental Hygiene states that as a large proportion of these diseases are emotional, they should be looked for and recognized in the schools, and although we have the Binney classes for defectives, there is no effort made in our public schools to discover the pupils who are incapable of withstanding emotional stress and strain of the life of today. In a few cities psychologists have been placed to examine for mental deficiency, but there are no psychiatrists to discover the emotionally unfit.

Again, in this increasing number of insane, feeble-minded, and criminal, we know that no matter how favorable the surroundings, their offspring will be more or less similarly tainted. We, as doctors, must recognize the scientific fact that society should demand that they be sterilized, so that future generations will not be increasingly burdened with their offspring. In my opinion, the time has now come when we must reconstruct our policy, look facts in the face, and distinguish between real progress and simply a continuation of relief work; we should spend less money for relief and more for prevention.

A short time ago your Welfare Committee was granted an interview with the Governor, during which they called his attention to the fact that the medical profession feels that it is best qualified to be of assistance in all medical matters. That, so far from being called upon to handle them, it has, up to the present time, had little to do with the formation of the medical policies of the state. That the present Department of Institutions and Agencies has not taken advantage of the offer we made them of furnishing reliable medical men who would act on their boards at great personal sacrifice; that those in charge of the Board were laymen without the requisite scientific knowledge for the efficient direction of medical affairs. That the Medical Society of the State of New Jersey, through its Welfare Committee, is organized entirely for service. It regards being of assistance to the state as its high duty. That we are not a political body looking for political positions, but one and all loyal citizens, and that the chief service that the profession can render is to do all in its power to interest every doctor in all medical matters of the state, and the

state can profit if our co-operation be asked in constructive councils.

The following suggestions were made to the Governor and have been accepted by him:

There shall be formed a so-called "Medical Advisory Board," consisting of five physicians, appointed by the Governor from a list submitted by the Medical Society of New Jersey, whose duty shall be to render assistance to His Excellency or to the Department of Institutions and Agencies, or any department of the State Government, in matters pertaining to health policies of the State or the wards of the State, and to disseminate such knowledge among the medical profession with the purpose of the technical and scientific knowledge of the medical profession at the disposal of the State, and of interesting the medical profession in public health problems.

The Advisory Board shall be presided over by a chairman selected by the Governor. They shall meet at least once monthly at the call of the Governor or the Department of the Board of Institutions and Agencies. They shall serve without any compensation whatever, direct or indirect, for the period of the Governor's Administration, or until relieved from duty by him.

This Board has been appointed with Dr. Elias J. Marsh of Paterson as chairman.

Finances:—During the past year your Society has expended \$2,789.25 through the Welfare Committee.

Legislation:—Viewed from actual legislative work accomplished, our activities would be regarded as more or less a failure, but viewed in the larger light of furthering the interests and ideals of the medical profession, the work has been eminently successful.

Veneral Control:—The principal bills decided upon for legislative action were for the regulation of venereal disease control, one containing amendments to the present enforcement act, the other a Marriage Certificate bill. The latter provided that persons before being allowed to marry, should have a certificate from a physician certifying either from examination or from questioning that the physician, to the best of his knowledge and belief, regarded the applicants to be sufficiently free from venereal disease in a communicable form. Copies of the drafted bill were mailed to the various county medical societies with a request for their approval of the measure. At the

time it was realized by your committee that, if the various county societies were to begin discussion of the bill, there was sure to be enough objectors from misunderstanding and difference of opinion as to various aspects to endanger the passage of the measure. But your committee felt that it would rather have the bills defeated than have any member of the profession feel that he had not been consulted. Many physicians refused to support the Marriage Certificate Bill. The Medical Societies of Salem and Somerset Counties opposed the measures, and wrote their senators asking them not to vote for them. The two legislators gave this as their reason for not voting. The result in the Legislature was that the bill was lost, as only eight senators voted for it, two against it, ten refraining from any vote, with one absentee. The bill amending the Venereal Disease Enforcement law was killed by the sentiment against the Marriage Certificate Bill.

Chiropractic Situation:—The chiropractors and the State Board of Medical Examiners were active in advocating a bill which would license those who had failed to obtain a license from the original board of chiropractors under the first chiropractic law or were in school or practicing at that time. Your Welfare Committee opposed the passage of this bill, but the lobbying strength behind it caused the enactment of a substitute measure. The opposition resulted, however, in many alterations and modifications from the original draft, chief and most important of which is a required examination before the State Board of Medical Examiners, so that a semblance at least of educational standards is still preserved. The vote in the Senate for the substitute measure was eleven, just the required number for passage, with no opposing vote. The House, which had at first defeated and later passed the original bill with amendments, adopted the substitute with only a few scattering votes in opposition. Your committee later appealed to Governor Silzer to veto the act, but without avail.

The same influence which had backed the chiropractors' bill, was also exerted for the passage of a naturopathy bill which, had it passed, would have licensed almost any one with very little educational attainment to practice the healing art. Your committee appeared at a hearing in opposition at Trenton, and the

measure never came to a vote. From this it would appear that not a single piece of legislation that we advocated was passed, and that one piece that we opposed was enacted into law, albeit so modified that it is not absolutely unacceptable to those who are standing for educational standards.

It is, however, from the standpoint of things accomplished for the medical profession as a whole and for the public health, that the Welfare Committee feel pride in their work.

Workmen's Compensation:—The amendment to the Workmen's Compensation law which your committee succeeded in passing last year, strove to give the physicians adequate compensation. To protect employers against the few physicians who might overcharge, a scheme was prepared by your committee under which three physicians were to act in each Workmen's Compensation Court district in all disputes regarding medical fees—one physician to be nominated by the Department of Labor to represent the State, one by the employers, and one by the medical profession; these three to be appointed by the Commissioner of Labor. The scheme prepared by your committee was adopted by the Workmen's Bureau of the Department of Labor and is now in operation. Commissioner Bryant told me that it was a real constructive piece of work.

While there may be dissatisfaction among many physicians regarding their bills being cut down, each doctor can feel that if his bill is not paid in full, it is because he has failed to satisfy three fellow physicians, one of them appointed from the State Society, of the justness or legality of his claim; and must realize that his bill is either excessive for the work done, or there has been some technical error in the way it has been presented.

We have succeeded in making medical men the judges of the value of the services rendered. This is a great step in the furtherance of the program of "medical men for medical problems." As chairman of the Welfare Committee I think that this alone justifies a continuation of the work.

Nursing Situation:—In conjunction with the Hospital Standardization Committee, the Welfare Committee gave a great deal of consideration to the nursing situation in the State. A plan was evolved to

create a new class of nurses to be known as trained attendants, who are to receive an intensive training over one year, doing certain work in hospitals and homes of a nature that does not require a fully trained nurse.

Conferences were held with representatives of nurses' organizations, and on one occasion, with physicians, nurses and hospital managers. The question was discussed at length, the general opinion being that such a class of nurse attendants should be created and trained in hospitals. This plan in the near future should furnish adequate care to the sick and suffering of this State.

The Study of the State Medical Laws:—Your committee during the past year has collected the medical laws of all the states; and considerable study has been given to the possibility of the necessity of a revision of the medical art with the idea of placing the decision as to the educational requirements up to the State Board of Education, with examinations before the Medical Board of the State; a plan similar to that which was once in effect in Illinois, but which was later declared unconstitutional.

The absurdities of our present medical laws are apparent to anybody who has contact with the law, and can be accounted for by the fact that up to the present time the profession as a whole has not taken the interest in the development of the medical practice act that its importance demands. It is like all legislation that is enacted by those who do not know the conditions thoroughly.

Your committee, during the past year, has succeeded in having the State Board of Medical Examiners so modify one of its rules that some of these absurd inconsistencies have been eliminated.

State Medicine:—Disguise it as we will, New Jersey, along with the other states, is headed for State Medicine. Many of the cities are today running medical clinics for school children, irrespective of their ability to pay. This is State Medicine whether we like it or not. Rehabilitation clinics all over the State are simply State Medicine in a disguised form.

My own idea is that one of the mistakes in New Jersey is its appropriation for rehabilitation. There already existed a machinery for rehabilitation,—the hospitals. These could accomplish all the desired results at the expenditure of comparatively little additional expense. Do

you want to continue? If you do, you, as the medical profession, should at least discuss the question and agree upon its exact form.

Expert Testimony:—Expert medical testimony has been a scandal for years, and under the present Workmen's Compensation Law, it is becoming a greater scandal. The profession must recognize this fact and deal with it firmly.

The Essex County Medical Society has formed a Committee on Medical Ethics which has been very active during the past season. To it has been referred a number of cases in which physicians have been charged with violations of the principles for which the profession stands. Such a committee should be formed in every county society, and should be in close co-operation with the Welfare Committee of the State.

Futures:—I think that next year we should not introduce any legislation into Trenton except the Venereal Control Bill, and one giving an injured workman the right to choose his own physician. In the venereal disease combat it would be a mistake to turn back now that we have put our hands to the plough, and thus acknowledge that we doctors are unable to meet a medical problem.

The Welfare Committee should have a definite program, and scheme for organization.

It should be made up of representatives from each county society; they should meet and pledge themselves to be present one day a month for eight months in the year; they should discuss medical problems; they should then turn to their county society and make a report of what is being done.

At the same time there should be sub-committees studying the problems especially pertaining to the interests of the profession, the Medical Practice Act, Workmen's Compensation, Venereal Control,—Sterilization. They should have a paid executive when they want him, and he should be in constant attendance when the Legislature meets. Bulletins should be issued to every member of the Society at intervals, thus keeping them posted in order to retain their interest in these matters pertaining to medicine in this State.

By such a program we shall be doing something constructive for our time and generation.

DISCUSSION

Dr. Horace M. Fooder, Williamstown: Mr. Chairman, I object to the report of the Welfare Committee on several points. First I want to give the Welfare Committee credit for many things that they have done. I will say for the Welfare Committee that the present Chiropractic bill, which was passed a year or two ago through the Legislature of the state was passed through their efforts and as the result of the co-ordination of the medical societies of the various counties; but I regret to say tonight that Dr. Eagleton has stretched the truth, and I want to put you right on this matter. I have the honor of representing the County of Gloucester in the Senate of the great State of New Jersey. I also have the honor of being the Chairman of the Public Health Committee in that body. The Welfare Committee was very kind in handing me various bills which they backed, to introduce for them, not because they loved me, but because they knew I was Chairman of the Public Health Committee, and several on that committee don't have very much use for me, and I think it is reciprocated. These venereal control bills they introduced through me were very good and they were backed by the various women's organizations and clubs of the state, which the ladies have a right to do. But I was surprised when these bills were called up before the Senate of the state, that there were so many letters written to the various senators of the state by various medical societies against them, and it was not only those letters that defeated the bills but also a circularization which was conducted by a religious sect—just why I don't know, but it was through their efforts mainly that the bill was defeated, they claiming that it took love out of marriage—and perhaps they were right. Now we come down to this famous Chiropractic Bill which I object to in the report of Dr. Eagleton. I was on the firing line and I am the one who knows the truth of that matter. He says "we" and I deny the "we"—not that I am egotistical about the thing, nor do I ask for any credit, but I think to him who deserves, the credit should be given.

He also slams the Medical Board for their propaganda in having this thing put through. The Medical Board had nothing to do with putting this thing through. They were not bought nor paid for. They had no influence in putting the bill through. They simply were advisers. This is the truth of that Chiropractors' bill: That bill went through the House, as it was introduced. It was what we call a blanket bill. It let every fellow come in who wanted to come in, irrespective of any qualifications or examinations or anything else. It was noised around that that bill would be given to another chairmanship, but fortunately the bill was given to the right chairman, to me as Chairman of the Public Health, where it belonged. Of course, being in a position of one who has always been very active in opposing the chiropractic bills as introduced, except the one that was introduced by the Welfare Committee, which is a very good one and now stands on the statute books. When this bill came to me, every influence and every method was used to get me to put this bill out as it was, as it came from the House, but I absolutely refused to do it. I had some pet bills

that meant a great deal to a city in my county, and they even threatened to murder those bills, using the language of the Legislature, but I said I did not care what they did, those bills were not going to go out as they were, and that one bill was going as Assembly 225. That was known as Assembly 225. Those men who were backing this bill came to me and threatened to get the co-operation of the osteopaths in putting across a bill including them in it, which would give the osteopaths their pet scheme in practicing medicine. You gentlemen don't know what that would mean, but I do, being on the inside. The osteopaths helped me, when I was over in the Assembly, to oppose the Chiropractic Bill, and while we lost, they were a wonderful help to me. I did not get a darn bit of help out of the Medical Society when the bill came up, there wasn't anybody there. They threatened me with all kinds of things to get this bill out. I said, "The only way for you fellows to get in is to have the same qualifications that these other fellows have, and take an examination." So they consulted among themselves and at last they found out that I was very emphatic on this matter, and they said, "We are willing to take that examination, but give us a chance to make the qualifications." I then thought the matter over and I consulted Dr. MacAlister on the matter. I said, "What does the Medical Board say on that?" And he said, "That is satisfactory to the Medical Board, if they will take the examination."

The Welfare Committee has a very honorable and a very nice man as their lobbyist, (you might as well use the term) Mr. Gunn, who I believe is a secretary of something or other and draws a salary. He is a mighty fine fellow and has given me a great deal of help, and I abide by his opinions a great deal, as coming from the Welfare Committee. So I went to Mr. Gunn and asked him what he thought about it, and he said, "I will take it up with the Welfare Committee." We waited and waited and we did not hear anything from the Welfare Committee, but at last they came down and said, "We won't stand for it." Then I went to the Medical Board again and said, "What do you think about it? Shall we allow these fellows to come in if they take the examination and make up the requirements?" They said that would be satisfactory. I felt they were the ones to be satisfied. I then went to Attorney-Generay McCrann and asked him what he thought of the bill when we made these little amendments in it. He did not have time to dwell on it very much and so Mr. Lanagan, his deputy, came along and we asked him. We took this bill, went into the Examining Board's room, and went over it very hurriedly and drew up this bill.

I then went to Mr. Gunn and asked him if he would not get the Welfare Committee together and ask them what they thought of it. We waited all day for them and did not hear a word from them. I then told him, "I will give you until nine o'clock tonight to get together on this thing and give me your word, and if you are not here at nine o'clock, I am going to introduce this bill because it is satisfactory to the Medical Board." So I gave this bill out and we had it mimeographed and we had it all ready to have it introduced. I waited until nine, and until half past nine, and then

suddenly Dr. MacAlister came to my chair in the Senate and said, "Dr. Costill is out here; he wants to see you." I said, "All right," and I got up and went out into the foyer of the Senet cahamber to see Dr. Costill. * * * * *

Now, that's who put through the Chiropractic Bill, and it was done with all sincerity. These fellows were simply given a chance. It was a fight between two schools of chiropractics: One got their bill through and the other fellows were left on the outside. These fellows were sincere. The ones who made up their examinations and they are in. It was done simply to quiet down this feeling of the chiropractics and the osteopaths and prevent them from getting together and putting across a bill demanding a separate board and making it very obnoxious to the physician. I also object to the slam that Dr. Eagleton took at the assemblymen of this state. He inferred that they were like a sheep and had no brains. I want to tell you that some of the best men of this state were members of the Assembly and they were men with brains and knew what they were doing. This Welfare Committee takes a slam at them and seems to enjoy slamming the Assemblymen. When I was an Assemblyman, they took a slam at me. When the Chiropractic bill was put across as a political matter, they said that if they had had better representatives in the Assembly it never would have gone through. I wrote a letter of response to that to the Journal and asked that the letter be published, but the Kaiser of the Journal refused to publish my letter. Next year you men are going to hear from the osteopaths with great big pamphlets through the Legislature, saying that they are better scholars than the medical men and saying that they should have a separate board. Watch out! I also introduced a bill giving the midwives a separate board. Attorney General McCrann told me that we have the best Medical Practice Act in the United States, and as soon as you start to monkey with it you are going to have the osteopaths and the chiropractics get together and you are going to have a separate board. That is my objection.

Dr. W. P. Eagleton, Newark:—What Dr. Fooder said about my slam at the Legislature is undoubtedly true. I say that I believe I could take some measures and if I could obtain the first three votes on them in loud voices, they would go through. I am glad to hear that Dr. Fooder thinks these Assemblymen knew all about the bills they are voting for. I don't see how it is possible that they could, in fact, it is impossible, and he knows it. He says I slammed the Medical Board. The chiropractors and the State Board of Medical Examiners were very active in advocating a bill which would allow those who had not obtained a license when the first Chiropractic Bill was in effect, to obtain a license after they had gone to school and received the necessary qualifications. That is the only reference to that. That is no slam. They were active. He objects to the words, "We succeeded," and he is right, that is a fair objection. It was through Dr. Fooder's assistance that educational requirements were put into these bills. We could not have done that, perhaps, without him, but he forgot the fact that we circularized the entire state and that every Assembly-

man who went there for the first bill that he is talking about voted it because it came from the doctors. Then they modified it and it went through. He is entitled to a great deal of credit for having put in educational requirements, because remember this, gentlemen: The original Chiropractic bill for which Dr. Fooder voted before the Welfare Committee became active did not call for any educational requirements, except an examination which could have been made up of anything they pleased.

There is no quarrel between the Welfare Committee and Dr. Fooder. I am sorry that he thinks there is. He and Dr. Costill had a personal altercation, unfortunately, at that time I was laid up with an infected hand in the hospital. I say it was an unfortunate thing, a misunderstanding between both the men. It was unfortunate that it came up on the floor. Outside of that, I say I can see nothing in Dr. Fooder's remarks—perhaps I am mistaken—in which there is anything that is not exactly the facts as I have presented them, and we are very much obliged to Dr. Fooder for the support he gave. However, we also know that before Dr. Fooder took this matter in hand at all, we defeated the original Chiropractic Bill, although it went back and became amended; and we thank him for his assistance. There should not be, between the members of the Senate or the Welfare Committee of the members of this Society, any difference of opinion or dissention, and I don't believe there is.

The report of the committee and its suggestions were, on motion, adopted by a vote of 100 to 1.

MEDICAL DEFENCE AND INDEMNITY INSURANCE.

Report by Dr. C. C. Beling of Newark.

Presented at the Annual Meeting of the Society at Atlantic City, June, 1923.

As Chairman of the Committee of Medical Defence and Indemnity Insurance, I would like to state at the present time that the present group policy for the State Society was issued on October 10, 1922, and up to June 18, 1923, 226 members had subscribed for and received certificates under this plan. This number would have been much larger but for the fact that the County Societies of Hudson, Monmouth, Bergen and Middlesex had taken out separate and similar contracts with the same company. So that I learned that approximately there were about 119 insured in these counties, making a total of 345 members insured for the year, under this new plan that was sanctioned by the State Society at its last meeting.

In view of the fact of the company's experience with this form of insurance, the Committee has been able to get the company to reduce its premium for the next year, so that we will have a reduction of

two dollars in the basic rate, or a rate of sixteen dollars for the same contract, with the understanding that the Medical Society of New Jersey shall endeavor, if possible, to obtain at least 500 subscribers.

I received a communication from the Secretary of the Essex County Medical Society, who stated that a proposition had been submitted to the Essex County Medical Society by an insurance company from a distant State, offering insurance of \$10,000 and \$30,000 for a premium of \$21 and a premium of \$15 for from \$5,000 to \$15,000 limits. The Committee has considered this but does not think the proposition compares with that which we now have with the U. S. Fidelity and Guaranty Company in Baltimore. The company that was recommended by the Essex County Medical Society does not grant the doctor the final disposition of his own case, and it demands that all notices, summons and other papers received should be forwarded to this distant State; so that the Committee does not recommend any change in the present contract, and it is important, because of the increasing cost to the State Society on their present medical defence plan, that we should all take out this form of indemnity insurance.

During the coming year we hope to present, in the pages of the Journal, matters relating to indemnity insurance, and I trust that at least all of the members will look at the Journal because the report made by the Committee has not been read, I think, by a large number of the members.

DISCUSSION

Dr. W. P. Eagleton: Will the doctor explain once more how the present method that he has, is superior to that of the other company's? I think he is mistaken about the Essex County Society turning it over to another company. It was put up to Essex County, and they, knowing that Dr. Beling knew all about it, referred it to him. I think it would be well to hear from Dr. Beling as to the advantages of the present method over that of the other company.

Dr. Beling: I have already stated, Dr. Eagleton, what the advantages were, but I will state them again. If I have said the Essex County Society recommended the adoption of this, I was in error. It was submitted by the Essex County Medical Society for the consideration of the State Committee; so I stand corrected if I said that, doctor. I said with regard to this other company, that the company does not grant the doctor the final disposition of his own case. The State Society members now have the final disposition of their own case; and that is one very important difference in the contract. Then the delay that would be occasioned by sending the

notices and summons to this distant state and bringing them back is another important factor.

With regard to the financial status and general responsibility and facilities for co-operation with the State Society, the company does not compare with the U. S. Fidelity and Guaranty of Baltimore.

Dr. T. W. Harvey: Mr. President, every now and then some one comes to me and tells me a yarn about what these other companies propose, and recently one of the things that an agent suggested as a point in which his company was superior to the company with which the State Society has its contract was the fact that besides the injured parties being able to claim for recompense and liability, their wives, daughters or sons and anybody interested were also justified in making a claim upon the doctor, and that their company protected the doctor from such suit, while the Maryland company did not. That is the way it was brought to me and I don't know how to answer that. I ask the doctor to answer, because if I have run into that, some of the other doctors must have also encountered it and they must feel some interest in it.

Dr. Beling: The answer to that is that I took that matter up with the agent of the U. S. Fidelity and Guaranty Company, and in their contract they undertake to defend in the name and behalf of the assured any suit brought against the assured, to enforce a claim, whether groundless or not, for damages on account of bodily injuries or death suffered, or alleged to have been suffered by any person or persons in consequence of any malpractice, error or mistake. It undertakes to defend any suit and to pay indemnity for any claim, whether groundless or not, for damages on account of bodily injuries. There is only one thing: when the doctor is sued, he is sued either for the results of what he has done; that is, for bodily injury, or death, and anything resulting from it the company undertakes to protect.

Dr. J. B. Morrison: They go even farther than that. You just read that the company insures against any claim of person or persons, and the persons include any suit that the relatives might bring for loss of time.

Dr. Beling: Yes, sir. Thank you for your attention, gentlemen.

Dr. Eagleton: Don't you think the members of the Society should know more about this matter than they do? Speaking for Essex County, we were not well informed. I suppose it was our own fault. However, it does seem to me that the State Society owes Dr. Beling more support and the attention of the individual members should be brought to the advantages of what he is offering.

President Hunter: Dr. Beling has made a painstaking, thorough investigation; he has written up this matter in extenso in the October Journal and if the members do not know about the details, it is their own fault.

CORRESPONDENCE.

Internal Revenue Department Ruling.

Portland, Maine, August 11, 1923.

Dear Doctor English:

I want to hear from you very much concerning the abrogation of 1369 Ruling of the Internal Revenue Department under which no deductions are allowed to physicians for costs of attending medical conventions. I am writing to the President, and to Dr. Work, and to the Internal Revenue Bureau protesting against this double taxation. For, we pay our costs of attending conventions to learn items of value for our patients and incidentally, through them, for the National Public Health. For such studies and efforts we should be encouraged to attend conventions by allowing deductions; whilst if no deductions are allowed we are discouraged to attend; and private health of our patients, health of patients in hospital under our care, and consequently the National Public Health all fall off, instead of being promoted.

Thinking that this position is plain, I say additionally, that in our absence from our offices attending such conventions for the benefit of the public health of the Nation we lose our entire income, for nobody can do our personal work as we do it. In this way of no deductions and of loss of income, we are doubly taxed. I ask you as Editor of your Journal to write something on these two points as you see fit, and thus to make the beginning of a nation-wide medical protest against an evident injustice.

Our programs as followed out are proof that our conventions are not like those of merchants, Masons, K. K. K., Koras, etc., etc., for mere sport and fun, but distinct attempts on the part of our able physicians to learn something new to add to the present sum total of medical knowledge of today.

I am leaving a similarly expressed letter with Dr. Morrison, your secretary.

Yours very truly,

JAMES A. SPAULDING.

Hospitals; Sanatoriums.

Bridgeton Needs Larger Hospital.—The greatly increased demands upon Bridgeton Hospital have led to a movement for a new and larger hospital. A building committee has been appointed and an effort will soon be made to raise the funds necessary for the erection of a much more commodious building.

Linn Hospital, Sussex.—This hospital will realize about \$1,500 receipts from the street fair and block party held in Sussex last month.

Bonnie Burn Sanatorium.—Dr. J. E. Runnells reports that on June 20th there were 251 patients in the Sanatorium, 139 males and 112 females. This included 77 children in the Preventorium. Since the last report 35 patients have been admitted, 17 males and 18 females. Ten of these admissions went to the Preventorium. The admissions are classified as follows: Pretubercular, 10; incipient, 4; moderately advanced, 3; far advanced, 18. Present July 27, 250. This number includes 79 children in the Preventorium, and 68 out of the county patients.

Browns-Mills Tuberculosis Sanatorium.—A building lot near Browns-Mills-in-the-Pines has been donated to the Burlington County Tuberculosis League by Harry L. Blow, a local resident, to be used as outing quarters for children predisposed to tuberculosis and anemia.

Essex Mountain Sanatorium.—The list of members of consulting staff will be given next month.

Deaths.

GARY.—At Ringoes, N. J., August 20, 1923, Dr. Arthur Dare Gary, aged 33 years. He graduated from Jefferson Medical College, Philadelphia, in 1912.

HAINES.—At Vincentown, N. J., June 21, 1923, Dr. Jacob Clifford Haines, aged 54 years. He graduated from the Baltimore University School of Medicine in 1898. He was a member of the County and State Medical Societies.

Public Health Items.

Newark Health Report.—The mortality report for the month of June shows that there were 405 deaths in Newark during the month, or a death rate of 11.1 per 1,000 of population. The principal causes of death were: Tuberculosis, 50 cases; cancer, 36; apoplexy, 29; organic heart disease, 50; pneumonia, 22; appendicitis, 11; Bright's disease, 33; congenital debility and malformation, 37. There were 957 births during the month.

Playground Showers.—The superintendent of recreation Paterson, has designed a shower device for children for hot days which yields a spray over a half circle 60 feet in diameter, and which has been set up at the fire stations and playgrounds of that city. It may be attached either to a fire hydrant or to any length of hose, and its volume is regulated by an operator in the "dry zone."

Tuberculosis Cows in Camden.—Thirty-seven cattle infected with tuberculosis have been ordered killed by Dr. David Helm, of the Camden department of health. Milk tests in each instance showed tuberculosis symptoms. During the last month Dr. Helm accompanied Inspector Townsend, of the New Jersey department of health, on an inspection tour of Camden dairies. The tour resulted in the slaughter of a large number of cattle supplying milk to the dairies.

Connecticut Program for Backward Children.—Connecticut is providing for her 3,500 backward and subnormal children, and more than forty classes are reported as already formed in Bridgeport, Hartford, Manchester, New Haven, Somersville, Stamford, Torrington, and Waterbury. More than 600 children have been placed in these classes, an average of fifteen children to each class. Some schools have two types of classes—one for children who are definitely feeble-minded and one for those who are merely backward.—The Nation's Health.

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A FEW IMPORTANT POINTS IN THE DIAGNOSIS OF PULMON- ARY TUBERCULOSIS.*

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I consider tuberculosis one of the most important, if not the most important disease which we as medical men have to fight. It is unnecessary for me to tell you the number of deaths in our country each year from this disease, for you are already familiar with the fact. But I should like to put the question, how many of these deaths are we, as physicians, responsible for, because we did not diagnose the disease in its incipient stage? And again, why do we sanatorium men have so many advanced and so few incipient cases admitted to our sanatoria?

Every case may be supposed to have had an incipient stage at some time which could have been diagnosed. Where does the fault lie? There are said to be 1,000,000 active cases and 1,000,000 inactive cases of tuberculosis in the United States. If this be true, is there any reason why we, as physicians, should not always be on the alert for this disease? Every physician has a number of patients who have indefinite symptoms, and it takes some time before a diagnosis is finally made. Do we always have in mind the possibility of pulmonary tuberculosis in these cases? Diagnosis is generally made by excluding one disease after another until the correct diagnosis is made. If we would consider tuberculosis one of the first to sus-

pect instead of leaving it until the last, we should, in a number of cases, make an earlier diagnosis of pulmonary disease. Perhaps we may see some cases diagnosed as tuberculosis which are not, but we more often see cases diagnosed as something else which are tuberculosis. We frequently see or hear of cases of run down condition, nervous indigestion, bronchitis, laryngitis, pleurisy, slow fever, autointoxication, or chronic pneumonia, which are really tuberculosis.

We must strip the chest of every patient who consults us if we expect to diagnose our cases in the incipient stage. Do not tell a patient that he has bronchitis, and give him a prescription for some expectorant mixture without first stripping his chest and examining his lungs for tuberculosis. It is absolutely impossible to make early diagnosis of tuberculosis by examining the lungs through the patient's clothing. What surgeon would make a diagnosis of appendicitis, gall bladder disease, peritonitis, or carcinoma of the stomach by examining the abdomen through the clothing? Not one. The first thing he says is, "Bare the abdomen." Tuberculosis men are not more skillful than surgeons.

Now I do not want to be misunderstood. I do not believe that we are to blame for all the cases of advanced pulmonary tuberculosis. Sometimes the patient does not seek the advice of a physician until the disease is long past its incipency. Some patients will take patent medicines and tonics for a long time before consulting a physician, thinking they are just run down. But if any of these cases have been under our care and we have not stripped the chest and examined the lungs, had sputum examined a number of times, taken temperature and pulse regularly for a period of two weeks, weighed patients each week, had x-ray pictures taken, and done everything possible to make a diagnosis, then we must assume

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the blame for these cases. And when we make a diagnosis of tuberculosis, let us not tell the patient that he has a spot on the lung, weak lungs, bronchitis, or a run down condition. These statements mean nothing to him. Let us tell him the truth in a nice way, and explain the course of the disease and what he must do to get well.

In making a diagnosis of tuberculosis, we should first take a very careful family and personal history of the patient. Ascertain whether he was a bottle or breast baby; whether he was exposed to tuberculosis during childhood; whether he ever had enlarged glands, cold abscesses, white swellings, or fistula in ano, which is generally tuberculous; whether he has scars and sinuses; whether he ever expectorated blood or streaked sputum; whether he has pains in chest; whether he has had typhoid or malaria; whether he is subject to frequent colds. A history of frequent colds is important, as ordinary colds or bronchitis do not last for weeks or months. Pay particular attention as to pleurisy, which is generally of tuberculous origin. Any patient with a history of pleurisy, simple or with effusion, should be advised that it is of tuberculous origin and that he should take the very best care of himself, such as getting extra rest and nourishment, and not overworking or overtaxing himself in any way; for if he does, he may develop active disease. Influenza, I believe, has lighted up more cases than anything else I know of. The usual statement of patients when taking their history is, "I have not been well since I had the Flu." This may have been any length of time from one month to one year or longer. Most patients date the onset of their illness from the time they had to stop work. I think it is better to ask them, "When were you perfectly well last?" That will generally date back several months, if not years.

Tuberculosis may follow any disease, but it more often follows influenza, measles, whooping cough, pneumonia, typhoid fever, and any of the acute infectious diseases. We have certain occupations which predispose to tuberculosis. Particularly susceptible to this disease are hatters, brass workers, granite workers, steel grinders, emery grinders, textile workers, marble cutters, potters, etc.

We have a number of laboratory tests which will assist us in making an early diagnosis of tuberculosis, such as tuberculin intradermic test, subcutaneous test, sputum test, complement fixation test, and x-ray pictures. I consider all of these very

valuable adjuncts in the diagnosis of tuberculosis, but we must not disregard our signs and symptoms should all of these tests prove negative.

If any patient expectorates blood at any time or anywhere, the blood should always be considered as coming from the lungs, and generally due to tuberculosis until it is proved otherwise. We very often see cases who never knew they were ill until they had a hemorrhage out of a clear sky. Put the patient in bed until you either confirm it as tuberculosis or exclude it. A short time in bed will not harm the patient if the case does not prove to be tuberculosis. If it does prove to be tuberculosis, you are just that many weeks ahead in treatment. Expectoration of blood is very often considered as coming from the stomach, due to gastric ulcer, from the tonsils, teeth, gums, throat, nose, from catarrhal condition, varicose veins of the esophagus, or from heart disease. I do not say that these conditions cannot cause blood spitting, but I do say that they are rare as compared to pulmonary tuberculosis. I sometimes say that I believe it would be a good thing for patients if every case of tuberculosis would expectorate some blood at the onset. He would be frightened, would consult his physician at once, and a diagnosis would be made early. Pulmonary hemorrhage is always an alarming complication, and we do not like to see it; but it is not always of bad prognostic omen. Cases running high temperatures often have a hemorrhage, after which the temperature falls, and an arrestment follows. I repeat, expectoration of blood should be considered as coming from the lungs and due to pulmonary tuberculosis until it is proved otherwise.

Temperature and pulse.—A careful study of these will give the physician as much information regarding a patient's condition as any one symptom. I do not mean to take the temperature once a day, and that in the morning, as only advanced cases have a temperature at that time of day. The temperature and pulse should be taken at 8 A. M., and 4 and 8 P. M. over a period of several days. In females we may have a slight rise in temperature just before and during the menstrual period. A sub-normal temperature in the morning with a pulse of 100 or over, if continued over a period of time, demands very careful study. A continued slight rise in temperature in the afternoon or evening of 99.2, 99.4 or over, with some other symptoms, such as loss of weight, strength, appetite and a few

night sweats, is very suggestive of tuberculosis. We often see these slight rises in temperature attributed to malaria, septic conditions, slow fever, para-typhoid, typhoid with negative widal, and auto-intoxication, when they are due to nothing but tuberculosis. We often hear of patients, especially the ladies, being complimented on their high color in the afternoon. This is not a sign of health, but a sign of disease; and if their temperatures were taken at this time, many cases would show a slight rise. This is what is called the hectic flush, and it is due to tuberculosis. Dr. Hawes of Boston says, "If the stethoscope were used less and the thermometer more, fewer mistakes would be made."

Loss of weight may be very slight or it may be very marked. A slight or marked loss of weight, unless it can be satisfactorily explained, should be considered an important symptom in the diagnosis of tuberculosis. Along with a loss of weight there is generally a loss of strength, which is very important, and often one of the very early symptoms. How often do we hear patients say, "Doctor, I haven't any strength or ambition." I once asked a physician, in taking his history, what his first symptoms were, and this was his answer: "I lost my steam. I would rather lie on the couch than get up and go into my office to see patients, although I knew I had to make a living for my family." Patients will tell us that they have to force themselves to do anything and where work used to be a pleasure, it is now a great burden. They are as tired in the morning as they are when they go to bed at night. A good night's sleep does not seem to rest them at all. I do not mean to say that every person who shows a loss of weight and strength has pulmonary tuberculosis; but I do say that these are very suspicious symptoms, and should demand a careful chest examination and study.

Night Sweats.—Night sweats appear as a very early symptom in some cases; in other cases they do not develop until the disease is far advanced; and other cases never have night sweats during the course of their disease. If, however, night sweats appear with other suspicious symptoms, we should always bear in mind tuberculosis as a possibility.

Cough.—Cough may be slight or excessive. Many patients will say that they do not cough at all. But if you keep on questioning them, they, or some member of the family will admit that they have a hacking cough in the morning. This cough may or

may not be productive. We often have a sort of croupy cough in children, which is very often due to enlarged bronchial glands.

Frequently there is no sputum early in the case. And in some cases, there is never any expectoration. In these cases, the temperature generally runs higher. Of course, when we examine the sputum, and find it positive, that confirms the diagnosis. A positive sputum is the only absolutely indisputable evidence of this disease. But unfortunately, this is rarely found in truly incipient cases. I fear that far too many cases are not diagnosed until the sputum is positive. We should never be satisfied with one negative sputum from a patient who presents other symptoms of tuberculosis. I recall a case where we made thirty-one examinations, all negative, and the thirty-second examination was positive. This patient had all physical signs and symptoms of tuberculosis, and it was diagnosed as such regardless of the negative sputum. In some cases, we never get a positive sputum, until the case is far advanced. Therefore, we cannot depend upon the sputum for a diagnosis in the incipient stage. We cannot tell by the looks of sputum whether it may or may not contain bacilli. A positive sputum confirms the diagnosis, but a negative sputum does not deny tuberculosis.

Sometimes the first symptom of tuberculosis is a gastro-intestinal disturbance, the so-called nervous indigestion. This condition may have lasted for several months and resisted all treatment with medicine. This gastro-intestinal condition is often secondary, and if the patient had been given a thorough chest examination, the lung condition would have been detected. The only way we shall ever be able to get our cases in the incipient stage is to give every patient a thorough chest examination, no matter what he consults us for. In this way we will pick out cases in the early stages.

Methods of Physical Examination.—Under this heading we should mention inspection, palpation, percussion, and auscultation. On inspection we note type of chest, retraction above or below the clavicle, bulging of the ribs as in effusion or empyema, amount of expansion, scars and discharging sinuses, movement of scapula, pulsations, enlarged glands, etc. These are all important points in making our diagnosis. On palpation we note a change in voice transmission. On percussion we may have from slight impairment in resonance to dullness, flatness, or tympany. On auscultation we may find harsh breath sounds,

cog-wheel and broncho-vesicular breathing, coarse and fine moist rales, and indeterminate rales. When we find fine moist rales following the expiratory cough, they are generally due to pulmonary tuberculosis. I think we pay too much attention to physical signs and not enough to symptoms. If we have symptoms of pulmonary tuberculosis, and we examine the chest and cannot find any signs in the lungs, are we going to dismiss the patient and say, "You are run down, but you have no trouble in your lungs," and simply pay no attention to the symptoms complained of? If we have symptoms without physical signs, we must consider them very seriously before dismissing them as of no value. On the other hand, if we have a patient who has had tuberculosis and still has a few crackles in his chest, but who presents no symptoms and feels and looks well, let us not be worried by these few crackles. The patient should be watched closely regarding his temperature, pulse rate, weight, and the amount of rest taken. We will probably find that he will go along without any trouble, and follow his usual occupation.

Tuberculosis nearly always begins at the apices and spreads downward. Any abnormal condition at the apices should be considered as tuberculosis until it is proven otherwise. Any abnormal condition at the base, with the apex clear, should be considered non-tuberculous until it is proven to be tuberculous. There are exceptions. Some time ago I visited Iola Sanatorium at Rochester, N. Y., and the superintendent, Dr. Lloyd, said that he had recently seen several cases of apparently primary basal infection, with positive sputums, and that he could not detect any trouble at the apex. I do not wish to convey the idea that every bit of pathology found in the lungs is tuberculosis. But I do believe that by far the greater part of it is tuberculosis. Conditions which may simulate tuberculosis are syphilis of the lung, growths in the lung and pleura, bronchiectasis, and chronic bronchitis. In these obscure cases where the diagnosis is uncertain, the x-ray will generally clear it up at once.

In conclusion, always take a careful family and personal history.

Always strip and examine the chest of every patient who consults you.

Consider simple pleurisy other than traumatic as generally tuberculous, and pleurisy with effusion as always tuberculous, and advise patient accordingly.

Consider any expectoration of blood as coming from the lungs and due to tuber-

culosis, until it is proven to be otherwise.

Be suspicious of patients with slight morning cough with or without expectoration, and showing loss of weight, strength, and appetite, with perhaps a few night sweats.

Any patient with continued rise of temperature and pulse unless accounted for should be considered as a suspicious case of tuberculosis.

Influenza cases with slow convalescence should be carefully watched.

I do not claim any original research work in the preparation of this paper. In fact, I feel sure it has been a repetition of what you have heard a number of times. However, experience has taught me that these few important points cannot be emphasized too often. My one plea is for the diagnosis of pulmonary tuberculosis in its incipient stage.

DISCUSSION

Dr. Alexander Armstrong, White Haven, Pa.—Mr. President, Ladies and Gentlemen: We have just listened to a very timely paper on a subject that appeals to all of us. It is my opinion, after following this line of work for more than fifteen years, that a paper of this character should be presented to every Medical Society, suppose we say in the world, at least once a year.

It is a subject that too many people have now an idea has been talked about too much. A great many doctors think that the campaign against tuberculosis is about over; but you physicians sitting here know that we are still signing too many death certificates for pulmonary and other forms of tuberculosis.

I would say, if we had more timely papers of this character, giving the plain facts regarding early diagnosis repeatedly, I believe the time would come when tuberculosis would become as rare as smallpox, for instance. That may seem visionary to some of you men here, especially those who do not believe that even now a cure of tuberculosis is possible, but that is within the vision of men in this line of work: that in from fifteen to twenty years, by still continuing only your present methods, I won't say of treatment, I will say of campaign against the enemy for, say, fifteen or twenty years, we will have practically eradicated tuberculosis; and should we in the next few years discover a specific, which is entirely possible and even probable, that time of course will be cut down materially.

We all know that the diagnosis is after all one of the very important things. There are very many phases to the tuberculosis question; but what concerns us as physicians is to get to know what is the trouble with our patients. And, while commending everything the doctor has said, I would agree with him also that we should not lay too great stress on what we hear in the chest. In other words, to make a diagnosis we should look at the composite picture and possibly lay more stress on the family history, the general history of the patient, and possibly some few prominent symptoms.

The addition, of course, or adjuvant, to our diagnosis, as you all know now, which we can all make use of, is the xray picture, and sometimes we think the xray tells us too much, and it then is, as Dr. Newcomb has said, the time that we must have some one interpret that plate, to tell us whether we have an active or an inactive or latent lesion, if this particular patient is losing ground, losing weight and strength, and even though we have no other definite symptoms, we are surely justified in putting the patient upon rest and the proper treatment and have him follow the outdoor plan of life for a certain period.

I am glad to say that the stigma, which it was a few years ago (possibly considered even yet to some), of having tuberculosis is passing away. Some day we may get to the point where the stigma of having social diseases may have passed away. Let us hope so. Then we won't need an argument like we had at the morning session. But to get at this we must face the question. We now know who the enemy is; we know where he lurks, and of course that is the reason the death rate has been reduced so materially in the last twenty years.

I can't touch on many subjects because I have not the time, but just one word about the sputum. I hope, gentlemen, that none of you are at least in the habit of waiting until you get a positive sputum to make a diagnosis of tuberculosis; not that a case isn't entirely curable after it has positive sputum, a case is entirely curable after it has positive sputum. There are thousands of people with positive sputum who are working. There are people sitting in this audience today who had positive sputum twenty years ago and are cured cases today and going about their work today. But it seems to me it is humiliating to us, as physicians, to wait to make a diagnosis, in these days of tuberculosis, until the patient has expectorated blood and has a positive sputum.

And I say, then, I want to emphasize these points: Take the composite picture, take your patient's history; go over his whole life from infancy, if necessary, and judge his present condition by whether he is keeping up to standard in weight and strength. (Applause.)

Dr. Berth S. Pollak, Secaucus—Mr. President and Gentlemen: The essayist and the gentleman selected to discuss the paper are recognized by our branch of medicine as competent and able diagnosticians and phthisiologists, and for that reason I believe that they have brought to your attention the most dominant factors in the diagnosis of tuberculosis. However, there might be some phases of that discussion that might be emphasized.

In the history, for instance, particularly of women, I would especially direct your attention to the fact that tuberculosis conditions become active after pregnancy, more particularly after labor; that the period of parturition and lactation is a period when much of the tuberculosis develops in women.

I would like to disagree, however, with my friend, Dr. Newcomb, in the statement which he has made and which I for many years believed myself that practically all ischio-rectal fistulas are of a tuberculous nature. I believed that until a few years ago Dr. Lynch delivered a lecture before the Hudson County Medical

Society on this topic, and when he was questioned concerning the percentage of the ischio-rectal fistulas which were of a tuberculous nature, he said that five per cent. of the ischio-rectal fistulas were of a tuberculous nature.

I would further emphasize that the return to academic inspection, palpation, percussion, and auscultation, is most important for a prompt and efficient diagnosis in tuberculosis, and I would particularly stress the great importance of light percussion, particularly percussing from the base upward, thus being able almost in all instances, by careful percussion, to map out the existing lesion. This is particularly valuable in early tuberculosis, where there is but infiltration and no degeneration, no absorption within the body of the degenerative process, and therefore we must resort to very careful physical examination in order to bring out the existing lesion.

I would also like to emphasize the fact, which has been alluded to by Dr. Newcomb and which cannot be too strongly emphasized, concerning the importance of the expectory cough, and I think it is only fair to assume that the statement which has been generally accepted by phthisiologists throughout the world is that rales appearing after cough and not disappearing, particularly at the apex, may be generally considered as pathognomonic of pulmonary tuberculosis.

There is one particular thing that I would like to refer to in closing, and that has been very substantially verified but recently in our service at the Jersey City Hospital where, as you know, we have a Department of Phthisiology for the benefit of the resident physicians, particularly, and the nurses. A case was brought into our service with a history of a frank pulmonary hemorrhage. The patient was examined by one of my assistants and he found (which was later substantiated by my associate and myself) a cavity at the apex of the left lung—a very easily demonstrated cavity. With the history of a hemorrhage, with the presence of rising temperature of 102, with expectoration, which was profuse, and with all the classical symptoms, the diagnosis was made of a pulmonary tuberculosis. On the next day, however, we found that the woman was expectorating a profuse amount of sputum, which, when tested, not by microscope, but when examined physically, we found was in layers, and we, therefore, resolved that our diagnosis had not been correctly made, and that we were dealing with a case of lung abscess.

We did the usual thing with this patient: Turned her upside down; let her drain out her pus, and then took her down to the xray room and fluoroscoped her. We fluoroscoped her after she had evacuated her pus and we found the cavity was empty. We then fluoroscoped her the next day when the cavity was full, and we were thoroughly satisfied that we were dealing with a case of lung abscess, probably due to tuberculosis, but not absolutely so.

A further study of the case revealed that within two or three days after this last fluoroscopic examination, she had another hemorrhage, and upon a very, very careful examination, gathering all our facts together, we were surprised to find that the woman was suffering

from a tumor of the lung, of which she died a week afterwards and which was proven by autopsy. So you see that it is very essential to be very careful in making a diagnosis and particularly in correlating all the facts in order to make sure of a diagnosis.

May I cite just another case that came to our notice last week, in order to show how careful we must be as to our diagnosis? A case was referred to our institution for acceptance as a case of tuberculosis. The history of the case was as follows: The man who had been actively employed had lost weight; had cough which was productive; had night sweats, and had all the classical symptoms of a pulmonary tuberculosis.

Upon examination, we found that all his lesion was limited to the lower lobes of both lungs. We found no evidence of any existing pathology in the upper lobes. We came to the conclusion that that was not a case of pulmonary tuberculosis, but was a case of infection such as we find following influenza. A careful repeated analysis of the sputum revealed no tubercle bacilli, but revealed streptococci and pneumococci. The x-ray pictures substantiated our diagnosis, that is, which we elicited on physical diagnosis, and revealed a lesion at the base of the lung.

Being that we were not in accord with the opinion of the physician who admitted this case, he was sent for final arbitration, so to speak, to Larrison Brown at Saranac. Larrison Brown carefully examined the case and told us subsequently that our diagnosis and finding was correct; that we had a case of streptococcus infection, limited to the base. I thank you.

Dr. Newcomb, closing discussion: If your patient has a fistula in ano be very careful about giving ether. These are often tubercular and the ether will light up the old condition in the lungs. What I am about to say does not come under this paper, but I would like to suggest to every surgeon that he have every patient's lungs examined by some good chest man before giving ether. If there is any trouble they should have chloroform or gas and oxygen. We sanatoria men see many cases each year which were apparently lighted up by ether during some operation.

County Medical Societies' Reports

BERGEN COUNTY.

Frederick S. Hallett, M.D., Secretary.

The Bergen County Medical Society resumed its monthly meetings at the Union League Club, Hackensack, September 11th. President Conrad in the chair and twenty members were present.

The Scientific Committee had prepared no regular program, but announced that "Travelers' Tales" would be in order. The members responded and a very pleasant event resulted. The next meeting will be held at the New Hospital, Hackensack.

MIDDLESEX COUNTY.

J. F. Weber, M.D., Secretary.

The regular quarterly meeting of the Middlesex County Medical Society was held on September 19, 1923, at the Nurses' Home of

the Perth Amboy City Hospital. Dr. C. W. Naulty, the president, called the meeting to order at 4.15 P.M.

A communication from the A. M. A. secretary was read concerning the sale of alcoholics, denouncing various practices to circumvent the law. This action of the A. M. A. was endorsed by this society and instructions for the secretary to notify A. M. A. secretary of the same.

A letter from Dr. W. P. Eagleton on welfare work was turned over to the County Welfare Committee for their action.

The names of Drs. V. P. Gauzza and James Grieves were ordered to be enrolled as members of this society on receiving word from the Credentials Committee.

Dr. D. C. English presented the following resolution, which was unanimously adopted:

Whereas, St. Peter's Episcopal Church of Perth Amboy is to celebrate its 225th anniversary on November 4th, and its rector, Rev. Dr. Jones, has suggested that the Medical Society of N. J. erect a tablet in that church to the memory of its first rector, Rev. Robert McKean, M.D., as the founder of our State Society in 1766, at a meeting called by him and thirteen others—mostly practitioners in this county—in New Brunswick July 23, 1766; therefore be it

Resolved, That the Middlesex County Medical Society hereby commends the proposition to erect such tablet to the favorable consideration of the Board of Trustees of our State Society;

Resolved further, That a delegation from the Middlesex County Medical Society attend the ceremony.

An exhaustive paper by Dr. C. A. Hofer was read concerning gastro-duodenal ulcer, after which he showed a number of x-ray plates demonstrating various gastro-enteric conditions.

A vote of thanks was given Dr. Hofer.

Dr. A. L. Hunt offered the following, which was unanimously adopted:

Resolved, That this society endorse the candidacy of Dr. A. L. Ellis for member of the assembly as one who, if elected, is especially qualified to represent the medical profession in matters relating to medical and sanitary legislation, and the society expresses the belief that it is important that the medical profession should be more largely represented in the State Legislature.

The president was authorized to appoint a Nominating Committee; also on motion of Dr. Haight, he is to appoint a Committee on Tuberculosis. Adjourned at 5.50 P. M.

MORRIS COUNTY.

Marcus A. Curry, M.D., Reporter.

The annual meeting of the Morris County Medical Society was held on the evening of September 11th in the auditorium of the main administration building of the New Jersey State Hospital at Morris Plains, upon invitation of Superintendent Curry and the Board of Managers.

President Lathrope presided over the meeting which was uncommonly well attended by the members. In addition there were present First District Councilor Dr. Mefford Run-

yon of South Orange and several of the newer physicians on the medical staff of the institution.

In the course of routine business a communication from the A. M. A. was read, bearing upon the unscrupulous prescribing of alcoholics; also a communication from Dr. Eagleton calling for volunteers to serve on various committees in the interests of the profession; and also the secretary read answers from candidates for nomination to the assembly to "soundings" sent to them as to their attitude toward the profession.

President Lathrope, as is the custom of the retiring president, delivered his address in which he not only reviewed the accomplishments for the year and set forth the plans in the making by the Executive Committee for the ensuing year, but also read a paper on "The Recognition of Early Pulmonary Tuberculosis," the entire paper making every moment of its reading highly interesting. (The paper is promised for publication in the Journal).

Two new proposals for membership in the society were received.

The election of officers for the ensuing year resulted in the following officers being unanimously chosen: President, George R. Hampton, Greystone Park; vice-president, William A. McMurtrie, Morristown; secretary, Henry W. Kice, Wharton; treasurer, F. Grendon Reed, Rockaway; reporter, Marcus A. Curry, Greystone Park.

Executive Committee: George B. Larson, Morristown; William F. Costello, Dover; George H. Lathrope, Morristown.

Committee on Credentials: Alfred A. Lewis, Morristown.

Annual Delegates: Edward Ackerman, of Dover; Noble H. Adsit, Succasunna; Harvey Arbuckle, Boonton. Alternate Delegates: Frederick M. Allen, Morristown; Augustus L. L. Baker, Dover; Gustav A. Becker, Morristown.

Referring to the annual meeting, President Lathrope said this meeting for a number of years has been held at the State Hospital at Morris Plains on the invitation of the superintendent and Board of Managers; that Dr. Curry, as superintendent of the hospital, has a difficult task which he is handling wonderfully well in the face of much discouragement; that he wants all of us to be familiar with this institution, which is one of the largest of its kind anywhere, and which is our institution as well as his; that he and his assistants, most of whom are members of the county society, need and deserve our support. Dr. Lathrope proposed a vote of thanks for the hospitality always enjoyed at the institution, which was freely and unanimously given.

With regard to the December meeting to be held in Morristown, Dr. Lathrope stated that the Executive Committee hoped to have Dr. Frederick M. Allen read a paper on the "Insulin Treatment of Diabetes"; that for the March meeting in Dover the committee plans to encourage its own members in original work by holding a symposium on some given topic for which the secretary will send out notices announcing the subject. Referring to the June meeting, the holding of which seems

to have become a fixture at the Shongum Sanatorium, Dr. Lathrope spoke in highly favorable terms of the kind of gatherings this meeting affords.

Superintendent Curry after announcing that Warden Bowen had prepared luncheon for the members and guests, emphasized the welcome that awaits the Morris County physicians who desire to and should become more familiar with the institution; stating that while some of the men know something about the institution, a great many know very little about it and should visit the institution more frequently than they do; that he wanted them to realize that a clinic is maintained at the institution and if he could be of any help to any of the physicians throughout the county, he is only too glad to help them. Referring to the half-mill tax which will realize from two million to two and a half million dollars for new buildings, Superintendent Curry said that while this seemed like a good deal of money, it was not so proportionally, when one stops to consider that there are at the institution over three thousand patients, with a capacity of two thousand, after opening up the new building last spring and the patient population goes on increasing year by year; and also there must be provided accommodations for the doctors, nurses and other workers as the increase goes on, if one is going to give the proper order of treatment to the patients; that the Governor, Comptroller and State Treasurer are very much in sympathy with us and realize the necessity for the increase of accommodations for patients and those who have to care for them; that the Governor has paid a personal visit to the institution and has gone through it carefully; and expressing the belief that the Governor is going to do something for the wards of the State.

During the appetizing luncheon the discussion of different topics bearing upon the future activities of the society was indicative of an aroused enthusiasm which should fructify for the good of the society.

BRITISH MEDICAL ASSO'N MEETING.

Dr. W. G. Schauffler's Report.

London, England, Aug. 14, 1923.

Dr. J. Bennett Morrison,
Recording Secretary, Medical Society
of New Jersey.

My dear Dr. Morrison:

According to my promise I am herewith sending you a brief account of my attendance at the Annual Meeting of the British Medical Association, which I hope may be of interest to the members of our Society, who were kind enough to elect me a delegate last June.

The British Medical Association met for its 91st Annual Meeting in the famous old seaport town of Portsmouth, where its sessions were held in the Municipal College and the very beautiful Town Hall. The Mayor and Council of Portsmouth, as well as the Naval and Military authorities co-operated with the medical men of the city to make this a memorable occasion, and the members of the Association and their families, coming from all over England, Scotland and Ireland and

the Colonies were royally entertained. C. P. Childe, Esq., B.A., F.R.C.S., M.R.C.P.E., President of the Association this year, is a Portsmouth man, a member of the City Council, and Chairman of its Committee on Health and Housing.

The meeting lasted from Friday, July 20th to Saturday, July 28th, and I should judge that there were from 500 to 600 delegates present, with perhaps nearly as many visitors. The first few week days were taken up with business meetings of the "Representative Body" made up of delegates from the various "Divisions" corresponding to our State Societies. On the last three days the "Sections" met from 9.45 to 12.45 each day and carried on the scientific work which was of a high grade. A very well equipped Pathological Museum added greatly to the general interest. The 16 Sections were more or less well attended, by far the most popular being that on "Medicine." It was most interesting to see that our British friends are confronted with the same problems and are working along the same lines, that so engross us at our own Annual Meetings. At none of the section meetings are any notes taken by the secretaries or stenographers. Each person opening a discussion or taking part in the same is expected to hand in to the Secretary of the Section in writing, what he wishes to have published.

Dr. Banting of Toronto was quite the center of interest on the first day, the Section on Medicine being crowded to hear him and the long interesting discussion following his paper.

The papers and discussions, which I was privileged to hear, were all quite above the average in interest.

A very interesting exhibit occupied the spacious gymnasium of the Royal Naval Barracks, about five minutes walk from the Municipal College. Here also lunch and tea were served at all hours. 84 exhibitors covered the usual fields of surgical and electrical instruments, x-ray apparatus, drugs, vaccines, appliances, books, tools, dental supplies, medicinal waters, etc. Several of the wellknown health resorts of England and the Continent had attractive books with pictures and Literature.

Among others I noticed the names of some of our old friends. Antiphlogistine, Phillips Chemical Co., Armour & Co., The Carrick Co., Horlick's Malted Milk, Rolynos, Nujol, Parke, Davis & Co., and I was quite forcibly reminded of the trials and tribulations of our long suffering Committee of Arrangements, when I heard the oft-repeated request, at the various section meetings, that the members of the Association should not fail to visit the exhibits and encourage the exhibitors.

On presenting my credentials as delegate from our Society, I was cordially received and accepted as a foreign guest of the Association. Before the President's address, held in the great hall of the Town Hall, the foreign guests and the representatives from the Colonies mounted the rostrum, when their names were called, and were individually greeted by the President. The scene was a gorgeous one, as it is the custom for the men to wear their academic robes on such occasions. The scarlet and red and blue robes and hoods, and the

various combinations of all these and other colors, together with the bright naval and military uniforms and the plainer full dress adorned with rows of glittering military orders was a sight never to be forgotten. The same costumes were worn at all evening functions on Tuesday afternoon in the historic and at the service held in honor of the Asso-St. Thomas' Church, when the venerable Bishop of Manchester preached a most appropriate sermon.

The banquet on Thursday evening was a most elaborate affair, attended by men and women and followed by many speakers. I had the good fortune to sit opposite Dr. C. Macfie Campbell, Director of the Boston Psychopathic Hospital, who was one of the section speakers, and the only other representative of the United States at the meeting, as far as I could ascertain.

Apart from the scientific and social program many excursions were arranged for the members and guests. I enjoyed greatly an auto trip to the Hayling Island Sanatorium, where the seashore branch of the Acton Hospital for tubercular children is situated. Sir William Trebar, Bart. and his efficient and devoted staff of nurses and teachers received us most cordially and demonstrated for us the open air methods used in caring for the 50 children under treatment for all sorts of joint troubles and lupus. The results are wonderful.

In closing I want to thank the Medical Society of New Jersey for honoring me by having given me the privilege of representing it at Portsmouth.

Very sincerely,

W. G. SCHAUFFLER.

American Association of Obstetricians, Gynecologists and Abdominal Surgeons.—This association met at the Bellevue-Stratford Hotel, in Philadelphia, on September 19, 20, and 21. Dr. G. K. Dickinson, Jersey City is president. Prof. Bovee read an able paper on "What Is Protoplasm" on Wednesday evening, the 19th inst., following that was the president's reception, preceded by the president's welcome. On Thursday morning the last paper was the president's annual address.

What This Country Needs

What this country needs is not a new birth of freedom, but the old-fashioned \$2.00 lower berth.

It isn't more liberty, but less people who take liberties with our liberty.

It is not a job for every man, but a real man for every job.

It isn't to get more taxes from the people, but for the people to get more from the taxes.

It is not more miles of territory, but more miles to the gallon.

It is more tractors and less detractors.

It isn't more young men making speed, but more young men planting spuds.

It is more paint on the old place and less paint on the young face.

It isn't a lower rate of interest on money, but a higher interest on work.

It is to follow the footprints of the fathers instead of the footsteps of the dancing master.

—St. Paul "Crescent,"

THE JOURNAL

OF THE

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Each member of the State Society is entitled to receive a copy of the JOURNAL every month. Any member failing to receive the paper will confer a favor by notifying the Publication Committee of the fact.

NOTE.—The transaction of business will be expedited, and prompt attention secured if,—

All papers, news items, reports for publication and any matters of medical or scientific interest, are sent direct to THE EDITOR, New Brunswick.

The County Society Secretary shall send promptly to Dr. Morrison, Secretary of the State Society, notice of the election of every new member, with his address; also of any changes of members' addresses.

All communications relating to reprints, subscriptions, extra copies of the JOURNAL, books for review, advertisements, or any matter pertaining to the business management of the JOURNAL are sent direct to THE CHAIRMAN OF THE PUBLICATION COMMITTEE, Newark.

ANNUAL DUES FOR 1924.

The dues for 1924 for the State Society are Five Dollars. They should be collected by January 1st, certainly not later than the 10th, and forwarded to State Treasurer Marsh immediately after they are received by the county society treasurer; otherwise the member not reported as having paid will not be enrolled in the Official List and will not be recognized by the A. M. A.

ANNUAL MEETING TRANSACTIONS.

We publish in this month's Journal the Transactions of the 157th Annual Meeting of our State Society, which occupies so much space that we are compelled to defer insertion of some Original Articles and other important matter till next month's issue, especially because we print sixteen pages more this month than usual.

We are always sorry to defer insertion of Original Articles from our own members, but there are good reasons why we sometimes feel compelled to do so, especially when we have enough papers to supply three or four issues of the Journal, and occasionally two from one member. Our members' papers are always welcomed, especially when they convey new thought on the etiology, symptoms and treatment of disease or report unusual cases treated.

Very rarely we insert papers of physicians residing outside of our State instead of a member's because of their timely importance or because the printer had set them up in time when the author of a member's paper had not returned proof sent him in time for insertion.

We always give papers read at the annual meeting preference, and usually in the order of their presentation, except the Orations and President's Address, which are inserted soon after the meeting. We are always pleased to receive criticism and invite any suggestions believed to be for the Journal's improvement.

INDEMNITY INSURANCE.

The form of group professional liability coverage issued to the Medical Society of New Jersey by the U. S. Fidelity Guarantee Company, offers the most liberal contract offered to any State medical society. The company has recently made a reduction in the basic rate from \$18 to \$16 which provides coverage in the amounts of \$5,000 and \$15,000, which may be doubled for a premium of \$21. Applications should be addressed to Louis O. Faulhaber, General Agent, 9-15 Clinton Ave., Newark, N. J.

DR. CHANDLER'S RESIGNATION.

The following resolutions were adopted by the Society (see Board of Trustees' meeting):

Whereas, We record with deep regret the resignation of

Dr. William J. Chandler

as Secretary of the Medical Society of New Jersey. Whereby the pleasant and intimate relations which have existed between us for twenty-two years have been severed, Therefore, be it

Resolved, That we express our appreciation of his unselfish labors on behalf of the Medical Society of New Jersey, and our sincere regret that he has found it necessary to sever his connection with this Society. During all his many years of service, Dr. Chandler has labored faithfully and efficiently, for the improvement of the Medical Society. Notwithstanding the demands made upon his time by the requirements of his profession, he has given his services generously, and performed the duties of the position to the satisfaction of all.

His agreeable character and genial disposition have endeared him to all his fellow members and he may always feel assured of our great personal regard for him.

Resolved, That these resolutions be

spread in full on the minutes and a copy presented to him with our sincere wishes that success may always attend him and that he may always enjoy the happiness and prosperity which he so justly deserves.

TABLET TO DR. MCKEAN.

(Reported elsewhere.)

We call special attention to the action of the Board of Trustees of our State Society ordering a Tablet to the memory of Rev. Robert McKean, M.D., the founder and first President of our Society, to be erected in the St. Peter's Episcopal Church, Perth Amboy, and to be unveiled at the 225th anniversary celebration of that church on November 4th.

We thank Rev. Dr. Jones, the rector of that church, for suggesting its erection, which is eminently proper as Dr. McKean was not only rector of that church and also practiced medicine in Perth Amboy in 1766, but was the first one to suggest the organization of the State Medical Society and to call the meeting of physicians in New Brunswick on July 23, 1766, when the organization was effected.

We congratulate Dr. Jones, and the officers and members of that church on its long, honorable and successful history and on the coming celebration in November, which our State Society's officers and Fellows will attend.

COMMISSIONER McBRIDE.

Governor Silzer has done the State of New Jersey a great service in appointing Dr. Andrew F. McBride of Paterson as Commissioner of Labor to succeed the late General Lewis T. Bryant. It is doubtful if there is another man in the State better—if as well—qualified for that high office. Like the Governor, he believes that public office is a public trust and that the duties of this very important office should be prosecuted for the public's welfare free from all political or other alliances that might prove harmful. The Editor of the Journal is well enough acquainted with the doctor and his professional and public work to heartily endorse the following taken from the Newark Evening News:

"The selection of Dr. McBride for this important post brings to a successful conclusion the Governor's efforts to find a particular type of man to take up the work of the Labor Department so efficiently conducted by the late General Bryant," the Governor's statement on the appointment sets forth. "It was the Governor's aim to find a man who possessed the necessary executive capacity and the human touch so essential to this particular position.

It has been the reputation of Dr. McBride that he has the qualities of mind that will permit him to thoroughly analyze a situation and then deal with it in a manner to bring justice to both sides of a controversy.

"It was while he was Mayor of Paterson that Dr. McBride earned his reputation as a public man. He established the policy of selecting the best man that he could find for a particular office. His experience as Mayor also peculiarly equips him for his duties as commissioner of labor. Paterson is a manufacturing city, and Mayor McBride had close relationship with both employers and employees. The practice of his profession and his service on the Paterson Board of Health also fit him in an exceptional manner for those duties as commissioner of labor that arise in connection with the sanitation and rehabilitation work of the department."

The doctor has been for several years a member of our State Society's Welfare Committee and he has rendered valuable service in its work.

In the report of the Welfare Committee given in the Sept. Journal, Dr. Marsh's name appeared, page 318, as chairman of the Advisory Committee. The chairman is Dr. A. L. Smith of New Brunswick.

SCIENTIFIC MEDICINE.

The spirit of modern medicine is scientific; it seeks to be open-minded toward new truth, provided this can be rationally related to the great body of firmly established and organized knowledge about nature, life, and mind, about which all scientific men agree. Scientific medicine cannot accept ideas which are merely mystical, or imply unknown and unverifiable physical or chemical properties, or involve supernatural intervention, or are in other ways clearly fantastic or beyond the reach of any available demonstration or experiment. So also modern medicine refuses to be labeled with the name of any school or cult. It is committed to no "pathy"; it knows no panacea; it is prejudiced only in favor of conclusions drawn by soundly reasoned processes from exact and verified facts. It recognizes the intricacy of its problems; it realizes that only a beginning has been made; it does not hesitate to admit ignorance or to suspend judgment. Its constant aim is the discovery of truth and its application to human need. These ideas, it must be admitted, are the conscious principles of a relatively small number of the medical men of the world. But the modern scientific spirit is permeating the great body of practitioners who have in the past too much relied upon dogmatic diagnosis, rule-of-thumb, "shotgun" prescriptions, and

a cheerful bedside manner. The personality and attitude of the physician toward his patients ought to be important sources of power and success but they should supplement rather than take the place of the scientific method and spirit.—Dr. George E. Vincent, *Rockefeller Foundation Review*

REINSTATED OR NEW MEMBERS. of the Medical Society of New Jersey.

Ambrose, Anthony, 71 Congress st., Newark.
Ballinger, Reeve L., 695 Kearny av., Arlington.
Blakeley, Edward W., 232 Ivy Court, Orange.
Brandenberg, Leo. W., Paterson Rd., Secaucus.
Brim, Anne J. S., 549 Clinton av., Newark.
Cohen, Maurice, 106 Valley rd., Montclair.
Creveling, Earl L., 169 Harrison av., Jer. City.
Echikson, Joseph I., 838 So. 12th st., Newark.
Goudy, Elmer G., 187 Kearny av., Kearny.
Jackson, E. C., 1019 Broad st., Newark.
Kline, Oram R., 620 Cooper st., Camden.
MacArthur, Clymont, 172 Roseville av., Newk
Norton, James F., 299 aVrick st., Jersey City.
Pflug, Ferdinand J., 1106 Bl'mfi'd st., Hoboken
Weston, C. G., 201 Ridgewood, Glen Ridge.
Wolfe, James C., 15 Gates av., Montclair.
Wyatt, Joseph H., 135 Clinton av., Newark.

BOARD OF TRUSTEES' MEETING.

The Board of Trustees of the State Society met at the Academy of Medicine, Newark, on September 21st, Chairman Sproul presiding. A resolution on Dr. Chandler's resignation reported by Dr. Dickinson, was unanimously adopted. (See editorial columns).

The secretary was directed to write to Governor Silzer, commending and thanking him for his appointment of Dr. McBride as Labor Commissioner; also to send a copy of it to each county society.

It was unanimously resolved to procure a Tablet to the memory of Rev. Robert McKean, M.D., the founder and first president of our State Society, and have it erected in St. Peter's Episcopal Church, Perth Amboy, prior to that church's celebration of its 225th anniversary on November 4th. Drs. Marsh, English and Morrison were appointed a committee to procure the Tablet. Treasurer Marsh reported about \$18,000 in the treasury and he was authorized to invest as much as he deemed best in U. S. Government securities.

The trustees, according to the order of the State Society, elected the following delegates to the A. M. A.: Regular delegates for the years 1924 and 1925, Drs. D. C. English and H. B. Costill; alternate delegates, Dr. G. H. Sexsmith for 1924, and Dr. James Hunter Jr. for 1925.

The secretary of the State Society was authorized to procure a filing cabinet for the preservation of society documents, etc.

Dr. Wells P. Eagleton, chairman of the Welfare Committee, presented a lengthy report which will be given in the November Journal.
D. C. English, Secretary.

Hospitals; Sanatoriums.

Hackensack Hospital.

The new Hackensack Hospital, embodying, it is said, the most modern facilities and devices for the surgical and medical treatment and care of patients, is practically completed. The structure cost nearly \$900,000, all of which was raised by public subscription after the old hospital was found to be inadequate. The old hospital, which was opened in 1901, has 125 beds and will be used in connection with the new one. The new hospital will accommodate 160 patients.

Salem County Hospital.

No war memorial in south Jersey has proved of such practical use as the county hospital established four years ago through the contributions of residents of Salem County, and supported since then by their voluntary donations. While the hospital has been for use of the general public, it has also been of real service to former soldiers and sailors. The cost per patient day averaged \$3.70 for the last year. There has been a steady growth in the service performed by this memorial hospital. Last year there were 663 admissions; 119 major operations and 203 minor operations; 40 deaths and 109 births.

State Hospital, Morris Plains.—The annual field day and occupational therapy exhibit at the State Hospital at Morris Plains September 15, was in its exhibits of patients' handicraft, more interesting than in previous years, its sponsors declare. It illustrated the progress made by patients under healthful and curative forms of employment. Superintendent Dr. Marcus A. Curry and Dr. George B. McMurray, occupational therapy director, personally conducted the affair, and among the judges were Governor Silzer, Commissioner of Institutions and Agencies Burdette C. Lewis, President of the Board of Managers Daniel S. Voorhees and other State officials.

Bonnie Burn Sanatorium.—Dr. John E. Runnells gives the following report for August: On July 31st, there were 255 patients in the Sanatorium, 144 males and 111 females. This included 77 children in the Preventorium. Since the last report, 29 patients have been admitted, 9 males and 20 females. Six of these admissions went to the Preventorium. Among these admissions were four re-admissions. These admissions are classified as follows: Pretubercular, 8; incipient, 1; moderately advanced, 5; far advanced, 15.

Essex Mountain Sanatorium.—The following compose the Consultant Staff at Verona, N. J., appointed by the Essex County Board of Freeholders:

Advisory and Consulting Staff—Dr. J. S. Brown, Montclair; Drs. I. Edward Gluckman, C. V. R. Bumsted and C. H. Ill, Newark; Dr. Ralph H. Hunt, East Orange.

Consulting Surgeons—Drs. M. Danzis, Edw. Staehlin, W. D. Minningham, Newark; Dr. M. Runyon, Orange; Dr. W. H. Areson, Montclair.
Consulting Physicians—Drs. C. E. Teeter, H. M. Ewing, M. Asher, Newark; H. C. Harris, Glen Ridge.
Nose and Throat—Drs. J. W.

Corwin, Newark; W. Bowers, Montclair. Eye and Ear—Drs. James White, Montclair; E. A. Curtis, Newark; Linn Emerson, Orange. X-ray—Drs. E. Reisman and Chas. Baker, Newark. Chest Surgeon—R. H. Dieffenbach, Newark. Brain Surgeon—Dr. W. P. Eagleton. Skin—Drs. H. A. Wallhauser and E. D. Newman, Newark. Gents' Wing—Drs. C. R. O'Crowley and S. C. Keller, Newark. Gynecology—Drs. E. J. Ill and C. L. Ill, Newark. Pediatrics—Drs. J. A. Caldwell, Montclair; E. W. Markens, Newark; F. H. Von Hofe, South Orange. Pathology—Drs. Otto Lowy, H. S. Mortland and G. L. Warren, Newark and G. P. Olcott, Jr., Orange. Neurologists—Drs. C. E. Beling, Newark and Guy Payne, Cedar Grove. Orthopedist—John K. Adams, East Orange.

Essex County Hospital for Contagious Diseases, Belleville, N. J.

Advisory Board: Drs. William H. Areson, Upper Montclair; William J. Runyan, Bloomfield; Sara Smalley, Newark; Clement Morris, Newark; Jas. Minor Maghee, West Orange.

Department of Otolaryngology. Consulting Surgeons: Drs. Wells P. Eagleton, W. C. Bowers, Harold Foster. Attending Surgeons: Drs. W. H. Brien, A. H. Richardson, Alfred Stahl, W. F. Beggs.

Department of Ophthalmology. Consulting Ophthalmologists: Drs. E. S. Sherman, Raymond Dodd.

Department of Pediatrics. Attending Pediatricians: Drs. A. R. Bianchi, Elizabeth Merceles, E. Mancuse Engara, Julius Levy.

Department of Dermatology: Drs. E. D. Newman, H. J. F. Wallhauser.

Department of Bronchoscopy and Laryngology: Dr. Henry B. Orton.

Department of Pathology. Consulting Pathologist: Dr. Harrison S. Martland. Attending Pathologist, Dr. John W. Gray.

Department of Roentgenology: Dr. Dudley E. Mackey.

Department of Surgery. Consulting Surgeons: Drs. James Spencer Brown, Frank Bunn, Francis R. Haussling, E. A. Ill. Attending Surgeons: Drs. Victor B. Seidler, D. Clark Thompson, Edw. P. Whelan. Attending Thoracic Surgeon: Richard H. Dieffenbach, Jr.

Department of Orthopedics. Consulting Surgeons: Drs. Edgar Holden, Jr., Robt. E. Soule.

Department of Anesthesia: Drs. Herbert Allen, Archer C. Bush, Frank W. Pinneo, James C. Wolfe.

Department of Medicine. Consulting Physicians: Drs. Charles E. Teeter, Albert Twitchell. Attending Physicians: Drs. Wm. D. Crecca, Geo. W. Davies, J. R. McCroskery, Louis Schneider. Tuberculosis Division: Dr. Edw. I. Gluckman.

Department of Cardiology: Dr. Harvey M. Ewing.

Department of Dentistry. Consulting Surgeons: Drs. Jas. B. Davidson, Walter F. Barry.

Glen Gardner Sanatorium.—The second annual reunion of former patients, doctors, nurses and social workers was held on September 15th, with large attendances. Addresses were delivered by Drs. Philip Jacobs, of the National Tuberculosis Association; B. S. Polak and S. B. English.

Marriage.

ROGERS-CLAYTON.—At Jamesburg, N. J., September 1st, 1923, Dr. William N. Rogers, of Trenton, to Miss Florence E. Clayton, of Jamesburg.

Death.

BAILEY.—At Elizabeth, N. J., September 16, 1923, Dr. Frederick Randolph Bailey, aged 52 years.

Dr. Bailey was born in Elizabeth, a son of the late Dr. George and Emma M. Bailey. He was graduated in 1892 from Princeton University. Three years later he graduated from the College of Physicians and Surgeons in New York, and for a number of years taught there as an assistant professor of histology. Later he became professor of histology and embryology. While engaged in teaching, Dr. Bailey began to practice medicine in Elizabeth, and in 1905 resigned from the faculty of the College of Physicians and Surgeons so that he could devote his entire time to his practice. Several textbooks of histology and embryology which Dr. Bailey wrote are still in use. He was a deacon of the Second Presbyterian Church. He was a member of the Clinic Society of the General Hospital, the New Jersey State Medical Society, Union County Medical Society, New York Academy of Medicine, American Medical Society, Elizabeth Lodge of Elks and the Rotary Club.

Further notice will be given next month.

COMMISSIONER OF LABOR McBRIDE.

Dr. Andrew F. McBride, Paterson, has been appointed by Governor Silzer Commissioner of Labor. He was born in Paterson January 4, 1869. He attended the Paterson schools, the private school of Professor McManus and was graduated from Columbia College. He began the practice of medicine in Paterson. In 1892 he was appointed to the Paterson Board of Health by Mayor Braun and continued a member of that body until he was elected Mayor in 1907. He served three terms of two years each. Prior to his election as Mayor he also served as county physician for eleven years. When the war broke out in 1917, Mr. McBride offered his services to his country in May. He was commissioned a captain in the Medical Corps in June. He reported for duty August 10, 1917, at Fort Benjamin, Harrison, Ind., and remained at this camp training enlisted men until November 27, 1917, when he was transferred to Camp Dix. While at Camp Dix he had charge of the epidemic division during the influenza outbreak. After the epidemic he became chief of the surgical division. In the fall of 1918 he was given the rank of major, and when he was mustered out at Camp Dix, March 15, 1919, it was as lieutenant colonel. After the war he resumed the practice of medicine in Paterson, where he is visiting surgeon at St. Joseph's Hospital. He is a member of the Democratic State Committee, succeeding the late Senator Hinchliffe. Although Paterson is normally Republican, Dr. McBride was always elected by large majorities.

OFFICIAL TRANSACTIONS

OF THE

157th Annual Meeting of the Medical Society of New Jersey

Held at Atlantic City, N. J., June 21st to 23d, 1923

Meeting of House of Delegates

THURSDAY MORNING SESSION

June 21, 1923

The One Hundred and Fifty-seventh Annual meeting of the Medical Society of New Jersey convened at ten-fifteen o'clock, at Haddon Hall, Atlantic City, N. J., Dr. James Hunter, Jr., President, presiding.

President Hunter: The meeting will now come to order and we will have the Invocation by the Rev. Thomas J. Cross, pastor of Chelsea Baptist Church, Atlantic City.

Rev. Dr. Thomas J. Cross: Our Heavenly Father, we are very grateful that we are alive and that our eyes can behold the wonderful works of God, for this new day, which means there shall come new tokens of God's interest in the children of men.

We ask now of Thee first of all to accept our thanks for permitting us to be alive and to have some share in Thy plans and in Thy purposes. Grant Thou a blessing upon Thy servants, and all along the journey of life make us conscious there is a place in which we can glorify God and help our fellow men. Grant Thou a blessing upon Thy children as we say together: Our Father Who art in heaven, hallowed be Thy name. Thy Kingdom come; Thy will be done, on earth as it is in Heaven. Give us this day our daily bread, and forgive us our trespasses as we forgive those who trespass against us. And lead us not into temptation but deliver us from evil. For Thine is the Kingdom and the power and the glory forever. Amen.

I hope you may have a profitable time here!

Secretary David C. English: I move you that the reverend gentleman who has led us in prayer be invited to sit as a corresponding member.

The motion was regularly seconded and carried.

President Hunter: The Address of Welcome was to have been delivered by Hon. Edward L. Bader, Mayor of Atlantic City, but he has sent in his place the Health Officer, Dr. Salasin of Atlantic City.

Dr. Samuel L. Salasin: Mr. President and Gentlemen: I am not going to give you an Address of Welcome; I am only

here to convey a message from the Mayor to this august body. He wants me to express his regrets in not being able to be here in person, inasmuch as he is in conference this morning and cannot get away, but he hopes that you will have a very profitable convention and that you will enjoy it. The Mayor desires to have you receive the key of the city and you may use it in any way, shape or form that you see fit. (Applause).

President Hunter: I hope there will be no occasion for unlocking the jail with this key. (Laughter)

The next item is Fraternal Greetings, by Dr. Clarence L. Andrews, President of the Atlantic County Medical Society. Dr. Andrews!

Dr. Clarence L. Andrews: Mr. President and Fellow Members of the State Medical Society: It gives me very great pleasure as spokesman for the Atlantic County Medical Society to welcome you to Atlantic City. Many of you are frequent visitors here and know the numerous attractions of our city as well as you know our local profession; yet a number of you are doubtless here for the first time.

Our Honorable Mayor has just given you the key of our city proper and it becomes my good fortune to unlock the city's Medical Cabinet, so to speak, and allow you full sway therein as well.

We are very proud of Atlantic City, perhaps largely due to the part we feel that the Medical Society has played in assisting its wonderful growth and wide influence, and also because of its being the Mecca of Medical Conventions and a place where every doctor longs to visit sooner or later.

This section of the Jersey Coast enjoys an international reputation for its healthfulness and cleanliness today, but I might say the idea is not a new one and can be found recorded in the writings of the early West Jersey settlers long before our city was even dreamed of.

From the very outset, however, it was a medical man who either expressed this belief or through some inquiry made by him, that this fact afterward became known. Therefore, the thought of just what future health value such a coast might become seemed to be the early dominant factor.

The best evidence of just what part the medical man played in citing an early interest in the healthfulness of the Jersey Coast can be given by referring to a paper published some time ago on "Reminiscences of Atlantic County Physicians," by Dr. Philip Marvel, Sr. Quoting from this paper, one finds that Gabriel Thomas in the 17th century, in writing about the early New Jersey colonies, said: "Of doctors and lawyers, I shall say nothing, as this country is very peaceful and healthy." Later on Dr. John Gordon, writing to his brother in England, said: "If you design to come hither, you may come as a planter or merchant, but as a doctor I cannot advise you, as I hear of no diseases to cure, but some agues and cut fingers and legs."

Dr. Jonathan Pitney, formerly of Morris County, settled at Absecon in 1819 and made frequent trips to the seashore by conveyance and noticed the cleanliness of the sand dunes, the absence of mud puddles, and the purity of the air. He made this fact known, and subsequently the Government lighthouse was built. Hence he might rightly be called the father of Atlantic City. In 1854 a charter for Atlantic City was granted and in 1880 the Atlantic County Medical Society was organized. Out of these eight pioneers who founded the Society which we now enjoy, only one member survives, and he is Dr. E. A. Madden of Absecon, New Jersey. From that small nucleus a greater Society has grown and while at times there has been a lull in progress and a wane in enthusiasm, the general march has been forward.

Now, just what part, if any, has the Atlantic County Medical Society played in making the city what it is? We say a very great part, because as one goes back and attempts to trace the development of the city from its early life till today, he can easily see that the two have developed hand in hand. There are two very strong and outstanding factors which have made our rapid growth and increasing popularity possible: First of all, the strong belief from the outset, as expressed by medical men, that real virtue lay in the healthfulness of the Jersey Coast, which inspired hotel men to cast their lots here; and secondly, an early attempt by the pioneers to make this a convention city.

A great honor is due the early members of our Society who used their influence to bring the American Medical Association, representing as it did the whole United States, and disseminated a great deal of medical truth about our climate, which has

come back to us in a thousand fold. Out of this beginning has grown our great convention city, and no conventions are more eagerly sought after by the Hotel Men's Association and Publicity Bureau than the medical ones are. Thus far this year nine medical conventions have met here, all of them national except our own. Hence you see, progress of one is symbolic of the advancement of the other.

It was the doctors' early conception of what Atlantic City had to offer in the way of pure air and healthfulness that prompted him to send his patients here, and out of this confidence expressed by many who returned from time to time has grown our great hotel structures, the boardwalk, and the peculiar types of entertainment which make the city what it is today.

The State Society has met here many times and in no city are you more welcome than here.

Each member of the Atlantic County Medical Society will take great pleasure in trying to make this the most pleasant and the most sociable and profitable meeting you have ever had. Thank you! (Applause).

President Hunter: The next item on the order of business is the report of the Committee on Credentials, Dr. W. J. Carrington, Corresponding Secretary, Chairman.

Dr. W. J. Carrington: Mr. Chairman, the Committee on Credentials is in continuous session on the floor below, opposite the elevator, among the exhibitors. That is all the report, I guess, we have to make at this time. The attendance up to date is a little above 200—I haven't the exact figures.

We have a graphic chart there, illustrated with thumbtacks representing the members and guests from each county. You can see that at the close of each session. (Applause).

President Hunter: The next item is the reading of the minutes of the 1922 meeting, Dr. Chandler.

Dr. William J. Chandler: The minutes of the 1922 meeting were published in the October Journal, and, barring some typographical errors, are correct. I move that they be accepted as the minutes of our 1922 meeting.

The motion was seconded by Dr. Costill and carried.

President Hunter: The next item is the Report on Permanent Delegates.

Dr. Chandler: Gentlemen, this report is unfortunately in my trunk, which has not yet arrived. It was lost on the way, somewhere between here and Newark.

I can report, however, that we have in the neighborhood of 186 permanent dele-

gates now on our list, and I am sorry I haven't the report here because I wanted to report some members who were not reported as present.

Dr. W. B. Johnson: I move that the reading of the report be dispensed with until a later session.

The motion was seconded by Dr. Weeks and carried.

President Hunter: The Nominees for Permanent Delegates will be laid over with the others. Election of Permanent Delegates will also go over.

Report of the Committee on Arrangements and Program, Dr. M. W. Reddan. If there is any committee that has worked harder for this Society, I don't know of it, and if our meeting is a success (which it promises in every way to be), it will very largely be due to the progressive, hard work of the Committee on Arrangements and Program, of which Dr. Reddan is chairman.

Dr. M. W. Reddan: If there has been any committee that has had any more fun out of its job than we have had, I would like to meet them. For instance, over the color of the badges, we knew that such a distinguished looking man as President Hunter did not need any distinguishing mark; and amongst the other committees we wanted to make this a scrappy organization, we wanted to make it come to time, so we adopted a militant color for all of you.

In regard to the work of this committee I want to say that Dr. Olmstead is the whole committee. He has worked night and day on this proposition, has handled piles and piles of correspondence, made trips to New York and Philadelphia, sent telegrams, and he has done an immense amount of work. He says that he isn't the whole committee, but after I tell you this little story I think you will believe that he is. He drove to the Van Sciver people across the River and said, "Wouldn't you like to furnish the platform and some of the committee rooms with your furniture?" They thought that would be a pretty good thing and agreed to do it. "Now," he said, "for one hundred dollars I will let you put your card on that furniture." (Laughter.) That is just a sample of the work that Dr. Olmstead is doing.

Dr. Reddan then read his prepared report.

Report of Committee on Program and Arrangements.

Your Committee on Program and Arrangements would report that we have thought first of the comfort and entertainment of our members and guests, and secondly of the cost. Notwithstanding this attitude we will have a nice balance to turn over to the Society.

| | |
|---|------------|
| We will receive from Exhibitors about | \$2,450.00 |
| From Program privilege..... | 500.00 |

The total income being about..\$2,910.00

There has been spent about \$1,000.00, of which the cost of badges was \$380.00. This is, we believe, an item which was heretofore paid by the Society, as was also the item of \$77.00 for mailing reprints of the program to every member. The cost for professional entertainers will be about \$300.00.

The cost of the ladies' entertainment we do not yet know, but we hope that all the coupons in the books will be used; as we have not counted these items as expenses but rather as investments in the good will and friendship of our members and guests—a far more valuable thing than money.

We wish to call your attention to the very fine line of exhibits and to bespeak for the exhibitors your attention and interest. We wish also to ask your interest in the advertisements in the Official Program.

The hotel management has been most courteous and obliging, no effort on their part being spared to make the exhibitors and those attending the convention comfortable in every way. We want to assure them of our sincere appreciation of their courtesy.

M. W. REDDAN, Chm.

Dr. Weeks: I move that the report be received and the committee thanked and congratulated.

The motion was seconded by Dr. Johnson.

President Hunter: Gentlemen, you have heard the motion, and before we put that to a vote I want to make this statement: That this work has been done at the expense of a large portion of Dr. Olmstead's time and effort. If we continue this committee, it seems to me it is up to the Society to pay them for the work, so they can employ competent help and not impinge too much on their time. I should say that twenty per cent of the gross income should go to the overhead keeping up the work of this splendid committee.

Dr. Alexander MacAlister: I amend the motion to that effect.

Dr. Weeks accepted the amendment. The motion as amended was carried.

President Hunter: The next is the report of the Committee on Scientific Work, by Dr. George Sommer, Chairman. We will pass that for the present and take up the Report of the Committee on Publication, which will be presented by Dr. Charles D. Bennett.

Dr. Bennett presented his report as follows:

Statement of Charles D. Bennett, Chairman of the Committee on Publication of the Medical Society of New Jersey.

Your committee is able to report another successful year with the business of the Jour-

nal, showing a clear, but small profit of \$300.43. This is a trifle less than the profit of last year but the difference is at once explained by the increases in salaries ordered at the last annual meeting and by the smaller membership of the State Society. Also the printing costs for 1922 were \$436 larger than in 1921, and while our advertising receipts were greater by \$210, yet as a larger proportion of this was secured by the Co-operative Bureau, our commissions were correspondingly larger and our net proceeds were thereby somewhat lessened. Still the Journal is in good financial condition and seems to be justifying its existence.

Complaints of wrong addresses have not been as numerous as in some former years, but still we receive many notifications from the postal authorities, such as "not found," "moved away," "unclaimed," etc., and unless we can in some way discover the new address, we are compelled to remove the name from the mailing list or pay return postage. This having been done, several months later we may receive a complaint that no Journal has reached the writer for many months. Of course this is usually the complainant's own fault, but much trouble is caused thereby and some unnecessary expense, and we therefore urge again that members notify the Publication Committee at once of any change of address, using preferably the address coupon printed in every issue of the Journal.

For the year ending Dec. 31st, 1922.

| Accounts | Receipts | Expenditures |
|-------------------------------|------------|--------------|
| 187 Printing and Mailing.. | | \$3,890.07 |
| 197 J'rnal (Sale of Copies)\$ | 10.05 | |
| 191 Reprint Account..... | | 44.55 |
| 205 Edi. Salary & Exp.... | | 1,929.80 |
| 207 Ch'rman's Sal'y & Exp. | | 678.05 |
| 211 Advertising | 4,637.80 | |
| 217 Cuts and Plates..... | | 12.85 |
| 221 Ext. Subscript's Acct.. | 41.90 | |
| 225 Mem. Subscript's Acct | 2,040.00 | |
| 227 Commissions | | 419.90 |
| 233 Discounts | | 95.38 |
| 93 Official List | 1.00 | |
| 79 Charged off, bad debts | | 33.00 |
| 239 Expense Accounts | 134.75 | |
| Bills Receivable | 542.53 | |
| Bills Payable | | |
| 239 NET PROFIT | | 300.43 |
| | \$7,408.03 | \$7,404.03 |

Comparative Statement

| | 1921 | 1922 |
|----------------------------|------------|------------|
| Advertising Receipts | \$4,427.97 | \$4,637.80 |
| Subscription (reg.) | 2,100.00 | 2,040.00 |
| Subscription (extra) | 23.90 | 41.90 |
| Sales of Journal | 11.27 | 10.05 |
| Dividend Received | 95.60 | 133.75 |
| Printing and Mailing— | | |
| Journal | \$3,454.17 | |
| Official List | 248.00 | 3,702.17 |
| Cuts and Plates | | 12.85 |
| Editorial Salary | 1,125.00 | 1,929.80 |
| Chairman's Salary | 375.00 | 678.05 |
| Reprints | 77.35 | 48.55 |
| Commissions | 371.87 | 419.90 |
| Discounts | 85.75 | 95.38 |

Amount of advertising secured by
Cooperative \$2,113.76

| | |
|---|----------|
| Amount of discount and commission allowed Cooperative | 503.88 |
| Amount of advertising secured by other sources | 2,524.04 |
| Amount of discount and commission allowed sources | 11.40 |
| Total amount of advertising | 4,637.80 |
| Total amount of discount and commission | 515.28 |
| NET PROCEEDS FROM ADVERTISING | 4,154.52 |
| The amount of \$33.00 was marked off for bad debts uncollectable and amount charged to loss and gain account. | |

| | | |
|---------------------------|------------|------------|
| Received from treasurer.. | \$5,375.00 | \$6,540.00 |
| Paid to treasurer..... | 4,014.05 | 4,067.49 |
| | \$1,360.95 | \$2,472.51 |

Amount per member

approximately \$.65 \$ 1.21

Editor's and Chairman's salaries due Dec. 31st, \$500; and printer's bill for December issue (\$308.45), should have been paid in December, 1921, but were not because the called for remittance from Treasurer was not forthcoming until January. Had they been paid as usual, the expense per member would have been only 81 cents for the year.

This also explains the unusually large amount paid for Editor's and Chairman's salary.

It was voted, upon motion of Dr. MacAlister, regularly seconded, that the report be received and placed on file.

President Hunter: The next is the Report of the Corresponding Secretary, Dr. Carrington.

Dr. Weeks: He will be here in a minute.

President Hunter: While we are waiting for the Corresponding Secretary to put in an appearance we will have the Report of the Recording Secretary, so as to save time. Dr. Chandler!

Dr. Chandler presented his report as follows:

Secretary's Report.

We are here today to celebrate our 156th anniversary. It was a far-seeing body of men who met together over a century and a half ago to establish a society, which should organize the medical profession of the State of New Jersey, advance medical science, and safeguard the interests of the profession. As we look back over the records of the past, we observe that it has done not only this, but has become a model for the organization of similar societies in the different states of this country.

At the present time especially we have cause to keep clearly before our eyes the standard of our forefathers and not allow our objectives to be in any respect lowered.

These are trying days for the profession. Various cults are seeking to enter our profession and to have the bars let down so that almost anyone may engage in the practice of medicine. As a result we see many efforts to put pernicious laws on our statute books, laws which would endanger public health and destroy human lives. This calls for perpetual watchfulness of our legislators to see what

laws are proposed and to prevent the passage of any which are likely to be detrimental to public interests. This work is distasteful to most physicians and they are very prone to shirk it. This should not be so and we should be willing to do our share.

The first meeting of this society was held in New Brunswick, on July 23, 1766, and was attended by seventeen men—truly a small number compared with our membership of today.

It is not my purpose to enter into a history of our society. That has been done before, but I do want to ask your attention to some of the work of this society today which is different from that of 150 years ago. Most of the men then knew one another, where each one lived. They knew too, how to spell their names and to find their residences. How vastly different today. One of the great difficulties in the way of tabulating the membership today is to know how to spell the names of the members, where they live, the correct number of the street as well as the town in which they live so that when a list is made out the name of the town, street and number may be correctly given.

Our by-laws require that each society secretary should send to the recording secretary at least one month before the annual meeting a roster of its total enrolled membership, and also a list of all who have paid their assessments and are otherwise in good standing. This by-law has been on our books for over twenty years and has not been changed in all that time.

Almost everyone looks to the recording secretary to know how many annual or permanent delegates his society is entitled, but how can your secretary tell when he is not informed as to how many members your individual society has. But this is not the greatest difficulty. Sometimes he is informed, but this information is in such undecipherable writing, that, with proper name especially, it is impossible to make out the correct orthography. Es, Is, As, Os, Ms, N, with a long-drawn-out K thrown in promiscuously make a very confusing puzzle for the secretary to study out and he frequently has to rely on a good guess as to how the name should be spelled. In the case of an old member the previous directory may help him out, or the telephone book may be called in to solve the correct orthography.

Then too the member may move to a new location, but how often does he send to the state secretary the name of his new address? Letters may be forwarded to him through the kindness of the postmaster at his old address, but not so with his Journal. This is not forwarded unless extra postage is paid and the Journal lies "dead" in the post office of the member's former address. Occasionally the postmaster returns the Journal and notes on it that the member has removed, and sometimes gives the new address. But the member seldom thinks to notify the secretary of the change in address and later perhaps writes to know why he does not receive his Journal. This is a common occurrence and will account many times for non-receipt of a Journal. First-class mail will be forwarded from place to place all over the country, but

not so with papers and other second-class mail. We have dwelt on this point at some length, because it is such a frequent neglect on the part of our membership. When a member changes his address he should at once inform the proper authorities, giving his old and new address so that the change may be made on the books, and he should be sure to WRITE LEGIBLY.

We have now about 2,000 members and it is not infrequent for erroneous names and addresses to creep in. There are several methods of overcoming this difficulty. One is to adopt the way of directory compilers and send to each member a printed slip on which he can place his full name and address and return it to the secretary of the State Society. This involves considerable time, correspondence and expense to the society and many times would be unavailing, as members are prone to delay, or even to neglect to send any reply whatever. A better way is for each member to take up the printed list, which was sent out this month with each copy of the Journal, find his own name and see if it is spelled properly and a correct address given. If there is any error, let him at once notify the recording secretary of the fact and giving the needed corrections. We shall thus be able to avoid errors of the past, and you will have the benefit of a full and reliable list. The names of some of our members are not in the printed list. This is either because their dues were not paid at the time when the list was printed or because they are new members and were not then reported.

Another point of much importance is for our society to fix a time for closing the list, after which time no names will be added thereto.

Our fiscal year begins on the First of January. All dues are expected to be paid for the next year on or before that date. If a leeway of one month is given, so that the books could be closed on the First of February, it would give all who desired to pay, ample time in which to keep up their good standing. The full lists could then be made up and printed early in the year, so that all could have an accurate and complete record of all the members in good standing and not be obliged to wait and accommodate the convenience of a few delinquent members. For various reasons the lists were not sent out this year until the present month—June—when they were sent to all subscribers with the June Journal. If any have not received their Journals I shall be pleased to ascertain the reason why, if they will send me their full names and post office addresses. So many errors have crept into our lists that there is no better way than for each member to examine the printed list and see if his name and address are correctly given and if not to immediately send to me his correct name and address so that I may have the proper changes made immediately. If the society today will fix the time for closing the list, it will be a spur to members to pay their dues promptly and all will profit thereby.

A man is said to be as "old as his arteries." The same may be said of medical societies. The arteries convey the nutrition to all the body, and thus keep it in vigorous growth.

Our society is old in years, but let us keep going by maintaining an active, educated body of men in all departments of our work. Thus shall we never grow old, but will have constantly within us sources of perpetual youth and be able to maintain our prestige in the medical world, to promote good fellowship and to benefit not only ourselves, but also the whole community in which we live.

Respectfully submitted,
WILLIAM J. CHANDLER.

Dr. Weeks: I move that the report be received and placed on file.

The motion was carried.

Now we will have the Report of the Corresponding Secretary, Dr. Carrington.

Dr. William J. Carrington: Mr. President, I think first we ought to pay tribute to Dr. Stout. I know better than any of you here the faithful work that he has done for this Society, because the records were turned over to me a month and a half ago and I cannot conceive of a man working more faithfully for any organization than Dr. Stout worked for the Medical Society of New Jersey.

I want to ask you to urge your friends to register. Last year and the year before, and probably years before that, those who came in late thought it unnecessary to register. There are a great many reasons why every one should register at this State Convention. The chief reason, however, is that the exhibitors base their acceptance of space upon the number who register. Now let us see that nobody gets away from here without registering, be he a member or guest.

At the right over here is a graphic chart on which the red thumb tacks represent members of the Society who are here, and up to the present moment only ninety-four have registered; there have been one hundred and seventy-three guests, including exhibitors, registered. Every county is represented excepting Sussex, Cape May and Ocean. This large epidemic here (indicating on chart) is Essex and Hudson. (Laughter).

Don't forget to register at the Registration Bureau on the floor below, opposite the elevator, among the other exhibits.

Dr. Weeks: I move that the report be accepted and placed on file. The motion was carried.

President Hunter: We will now call for the Report of the Committee on Scientific Work, Dr. George N. J. Sommer, Chairman. Dr. Sommer.

Dr. George N. J. Sommer: There is not much for the Chairman of the Scientific Program Committee to report. The program speaks for itself. However, I might suggest to any members who wish to appear

on the program next year, it is well to get their applications in early. A great many members apply for a place on the program about the time the program is being printed and therefore cannot be considered.

President Hunter: Gentlemen, you have heard the Report of the Committee on Scientific Work.

It was voted, upon motion of Dr. Sproul, regularly seconded, that the report be adopted and placed on file.

Dr. Claudius R. P. Fisher: Mr. President, Dr. Carrington, as Corresponding Secretary, spoke of our late Corresponding Secretary, Dr. Stout. I move you, sir, as a tribute to his memory, that we devote one minute of silence, while we remain standing in memory of Dr. Stout, our faithful Secretary for so many years.

The motion was seconded by Dr. Johnson and carried, the audience remaining standing one minute as a silent tribute to the memory of Dr. Stout.

President Hunter: The Report of the Board of Trustees, by Dr. English.

Dr. English presented the report as follows:

Report of the Board of Trustees.

The Board of Trustees held three meetings during the past year: One in September; one in October, and the other in December, 1922.

The principle business transactions were: Fixing the annual meeting at Haddon Hall, Atlantic City, on June 21-23, 1923; ordering the revised By-Laws printed and distributed; employing a competent stenographer for the annual meeting; adjusting accounts in Medical Defense cases; hearing and acting upon the Welfare Committee's report, appropriating \$2,789 for the committee's work; strongly endorsing Indemnity Insurance and urging members of the Society to adopt it instead of present methods of medical defense for their own better protection as well as for our Society's welfare.

The Board met last evening—June 20th—in Haddon Hall at 8.15 o'clock, Chairman Sproul presiding, with 16 members present.

Dr. O. H. Sproul was re-elected Chairman and Dr. D. C. Enblish was re-elected Secretary for the coming year.

A telegram was received from Dr. W. P. Eagleton stating it was impossible for him to attend the A. M. A. annual meeting in San Francisco, and suggested that the Trustees appoint a delegate in his place to represent our Society.

On motion it was resolved that a telegram be sent to our delegates now at San Francisco—Drs. Marvel and Halsey—authorizing them to appoint some member of our Society who is there as an alternate to Dr. Eagleton and to use the telegram as his credential.

A communication was received from the Stacy-Trent Hotel, Trenton, inviting the Society to hold its 1924 annual meeting in that hotel. It was on motion referred to the Committee on Nominations.

Dr. Hunter reported that in accordance with the Board's action in December he had secured Miss Schoenfeld to serve as our stenographer at this annual meeting and she was present at this meeting of the Trustees. He read a letter from the Master Reporting Co. that recommended her. The report was accepted and approved.

Treasurer Marsh read his report which showed the receipts for the year ending Dec. 31, 1922, to have been \$18,665.09, and the disbursements \$14,634.54, leaving a balance on hand Jan. 1, 1923, of \$4,030.55. He also reported that the present balance is \$14,596.87, with four government bonds and one Chicago and Alton R. R. bond also on hand. The report was accepted and approved and on motion the following was adopted:

Resolved, That the Treasurer be and he is hereby authorized to sell, assign or transfer the Chicago and Alton 3½ per cent., first lien 50-year gold bond belonging to the Society in such manner as may seem to him advisable for the protection of the Society's interest, and that any action already taken by him for this purpose is hereby approved and confirmed.

On motion Drs. Fisher, Ill and Hollingshead were appointed a committee to audit the Treasurer's accounts.

On motion it was recommended that the annual dues of members for the year 1924 be five dollars.

Dr. C. D. Bennett, chairman of the Publication Committee, presented his report, which showed receipts of 7,408.03, and the expenditure of \$7,107.60, leaving a net balance of \$300.43, for the year 1922. The report was accepted and approved, and the committee was, on motion, given power to correct defects in the methods of transmission of our Journal to our members.

Dr. D. C. English was re-elected Editor of the Journal for the year beginning July 1, 1923, on the same terms as last year, and at his suggestion he was given permission to select five associate editors, subject to the Publication Committee's approval.

Dr. Wells P. Eagleton gave an outline report of the work of the Welfare Committee, of which he is chairman, with an account of the expenditure of \$2,789. His report was accepted and heartily approved, and at his request was referred to the auditing committee.

Respectfully submitted,

D. C. ENGLISH, Secretary.

Dr. Weeks: I move that the report be accepted and placed on file.

The motion was carried.

President Hunter: We now come to the Report of the Committee on Revision of Constitution and By-Laws, Dr. Walter B. Johnson, Chairman.

Report of the Committee on Revision of the Constitution and By-Laws

CONSTITUTION.

ARTICLE I.

No change.

ARTICLE II.

Purpose of the Society.

OBJECT.—The purpose of this society shall be: First—To federate and organize the medi-

cal profession of the State of New Jersey. Second—To unite with similar organizations of other states, to compose the American Medical Association. Third—To advance medical science and elevate professional standards; to safeguard the material interests of the profession and promote friendly relations among its members; to educate the public in preventive medicine and hygiene and in all to make the medical profession most capable of rendering service to humanity.

ARTICLES III. and IV.

No change.

ARTICLE V.

Section 1. No change.

Section 2. Members of the house of delegates shall consist of the fellows, elected members of the Board of Trustees, officers of the society, permanent and annual delegates, reporters, councilors and chairmen of the standing committees.

ARTICLE VI.

Board of Trustees.

The Board of Trustees shall be the executive body of the society and shall be composed of the fellows, the president, the three vice-presidents, the recording secretary, the corresponding secretary, the treasurer, and five members from the house of delegates as provided in the by-laws.

ARTICLES VII., VIII.

No change.

ARTICLE IX.

Officers.

All officers, except the Fellows of the society and the members of the Board of Trustees elected at large as prescribed in the by-laws, shall hold office for one year, or until their successors are elected.

Section 2. The officers of The Medical Society of New Jersey, except the Fellows, shall be elected by the house of delegates in the afternoon of the second day of the annual meeting by ballot (a majority of the votes cast being necessary for an election), it being hereby provided that no member shall be eligible to more than one office at the same time, except the president, the three vice-presidents, the recording secretary, the corresponding secretary, and the treasurer, who, by virtue of their office, are members of the Board of Trustees. And it is further provided that in the event of a vacancy occurring between the annual meeting, the said vacancy shall be filled ad interim by the Board of Trustees.

ARTICLES X., XI., XII.

No change.

BY-LAWS.

CHAPTERS I., II., III.

No change.

House of Delegates.

Section 1. The House of Delegates shall meet at the time and place of the annual meeting of The Medical Society of New Jersey and shall arrange its sessions held for the president's address and for the annual orations.

Section 2. Twenty members, representing at least four component societies in good standing, shall constitute a quorum. All of the meetings of the House of Delegates shall be

open to the members of The Medical Society of New Jersey, but only members of the House of Delegates shall have a right to vote.

CHAPTERS III., IV., V.

No changes.

CHAPTER V.

Section 1. No change.

Election of Officers.

Section 2. The nominating committee shall be composed of the fellows and a delegate from each component society elected at the annual meeting of such component society, who shall present his credentials to the recording secretary as a member of the nominating committee from his county at the close of the first session of the annual meeting. It is hereby provided that the president of The Medical Society of New Jersey may appoint another delegate from the same county to take the place of the member of the nominating committee in the event of his absence. This committee shall meet at the close of the first session and report the result of its deliberations to the house of delegates in the form of a ticket containing the names of one or more members for each of the offices to be filled at the annual meeting, including nominations for trustees, standing committees, councilors, delegates to the American Medical Association, and to corresponding State medical organizations, etc.

Section 3. Five delegates shall be nominated and elected to the board of trustees from the component societies at large, one from each judicial district. It is hereby provided that the election of these trustees shall be as follows: One for five years; one for four years; one for three years, one for two years, and one for one year, and thereafter one each year for full term of five years. In the event of a vacancy by death, resignation, or otherwise, the president of the society shall appoint a member ad interim.

Section 4. Substitute Section 3 of the present by-laws without change.

Section 5. Substitute Section 4 of the present by-laws without change.

CHAPTER VI.

Section 1. No change.

Section 2. The vice-presidents shall assist the president in the discharge of his duties, and in the absence or disability of the president, the vice-president in order of seniority, shall preside at all meetings of The Medical Society of New Jersey and of the house of delegates, and perform all of the duties pertaining to the office. In the case of vacancy in the office of the president, by death, resignation, or removal, the vice-president in order of seniority shall perform all the duties pertaining to the office of the president during the interim until the first succeeding annual meeting thereafter.

Section 3. Strike out Section 3 and substitute Section 4 in its place.

Sections 5, 6, 7, to be changed to read, "Sections 4, 5 and 6," respectively.

Section 5. It shall be the duty of the Board of Trustees to organize annually and elect a chairman and secretary; to exercise a general supervision over the affairs of the society, with authority to recommend and to act for the society whenever necessary; to keep full

minutes of all meetings; to give the house of delegates a summarized brief of its proceedings and recommendations and to publish yearly in the Journal of The Medical Society of New Jersey a full report of the same; to acquire and hold official bond of the treasurer for the faithful execution of his duties; to annually audit his accounts and to include a statement of the same in the general report.

Dr. Walter B. Johnson: The Committee of Revision of the Constitution and By-Laws held a meeting and made a report last year, and there needs to be some little changes made.

In Article II of the Constitution we have changed the word "character" to "standards" and "to educate the public in preventive medicine and hygiene and in all to make the medical profession most capable of rendering service to humanity." Add the words "to make" and "rendering".

Then in Article VI of the Constitution: "The Board of Trustees shall be the executive body of the Society and shall be composed of the Fellows, the President, the three Vice-Presidents, the Recording Secretary, the Corresponding Secretary, the Treasurer, and five delegates, who shall be elected to the Board from the component societies at large, as provided for in Article IX."

Article XI of the Constitution: The first half of this is left out in order to cover Article IX: "Section 1. All officers except the trustees shall hold office for one year or until their successors are elected. Fellows who are trustees ex-officio shall hold office during life, and the five district trustees shall serve during the term for which they were elected.

"Section 2. The election of the officers of the Medical Society of New Jersey, by the House of Delegates, shall be held in the afternoon of the second day of the annual meeting by ballot, a majority of the votes cast being necessary to an election, it being hereby provided," and the rest of it is the same as it was in the printed report.

These changes were made, I believe, in consequence of action that was taken on the floor of the house last year—I am sorry I was not here, but I think that is the case.

Now in the matter of By-Laws, in order to make Chapter IX, the Committee Chapter, correct in its relation to the annotation of the names of the committees, we have changed the numbering of the sections, and in one instance where it was necessary to combine the Committee on Program and Arrangements into one committee where it had been published in the report in two committees, we have changed that section

from Section 2 of Chapter IX to Section 5, and this is Section 5:

"Committee on Program and Arrangements. The Committee on Program and Arrangements shall consist of five members, three of whom shall be elected as follows: One for three years, one for two years, one for one year, and thereafter one member to be elected every year to serve for the term of three years, who, with the President of the Society and the Recording Secretary as members ex-officio shall constitute the committee."

That is the Committee on Program and Arrangements.

"It shall be the duty of this committee to provide suitable accommodations for the meeting places of the Society; that is, the General Sessions, House of Delegates, Board of Trustees, the various committees and exhibits. This committee shall have charge of all matters and details pertaining to the general arrangement and shall have power to enlarge its membership by creating sub-committees as necessity or urgency may require.

"It shall be the further duty of this committee after receiving from the Committee on Scientific Work the titles, together with brief abstracts of the papers to be read, with authors names attached, to prepare and issue a program announcing the order in which the papers, discussions and all matters of business are to be presented, which order shall be followed as nearly as practicable. All papers must be announced to the Chairman of the committee thirty or more days before the annual meeting.

"The Chairman of the committee shall report in writing an outline of the arrangements to the President for his approval and shall subsequently have the program and announcements printed and mailed to each member of the Society."

This constitutes now the completed Constitution and By-Laws, which can be acted upon this year, due notice having been given last year, and no other changes in the Constitution and By-Laws can be made at this session.

Dr. Obadiah H. Sproul: I move that the Report of the Committee on Revision of the Constitution and By-Laws be received and its recommendations acted upon, and the subject matter continued in charge of the Committee on Revision until completed.

President Hunter: Gentlemen, you have heard the motion.

Dr. Wells P. Eagleton: Mr. President,

might I ask if it is planned to vote on these at this session?

President Hunter: Yes, Dr. Eagleton.

Dr. Eagleton: Have the suggestions as to alterations in the Constitution and By-Laws been published in the Journal?

Dr. Johnson: The By-Laws have been printed and sent out.

Dr. Eagleton: Have the suggested alterations to the Constitution appeared in the Journal?

Dr. Johnson: They have appeared in print.

Dr. Fisher: They have appeared where?

Dr. Johnson: I was not here last year. This committee prepared and presented at the Society meeting, in due form these alterations in the Constitution which could not be acted upon at that time. That copy was presented and I believe it was printed in the Journal.

Dr. English: No, sir; the constitutional amendments as reported by the committee last year seem to have been lost from the records and the whole matter has been worked up by the committee since.

Dr. Eagleton: The point that I wanted to bring out was this: The committee has worked very hard and we are all thoroughly behind the committee, but it seems to me that before any action of actually placing these rules on our books as our Constitution is taken, they should appear in this year's Journal and be acted upon next year, because they are of too great importance not to be considered first. I do not understand them and I am sure that others also may not understand them. Of course, I believe they are all right, but it seems to me every member of the Society, when it comes to a matter of the alteration of the Constitution or By-Laws, should have some way of knowing what is going to be done and those alterations should appear in this year's Journal and be acted upon at some time during the next annual meeting.

Dr. Fisher: Dr. Eagleton has stolen my thunder, sir. If those amendments have not been printed and put before each individual member of the Society, we cannot legally act upon them at this session. That refers to the Constitution, not the By-Laws.

Dr. Thomas W. Harvey: Mr. President, I think there was a provision in the Constitution that notice of changes having been given before, require a certain number of readings. We have taken action on various changes in the Constitution and By-Laws by giving them two readings at one session during the annual convention. I do not recall that the Constitution provides that

they should be published in the Journal, as my impression is that there was no Journal when the Constitution was adopted.

Dr. English: I believe if the members will refer to one of the issues of last year's Journal they will find that changes have been printed with reference to the By-Laws that have been offered for action this year; but there have been no changes with reference to the amendments to the Constitution printed in the Journal, and the point is well taken that they should not be acted upon until the members have had a chance to look them over in the Journal and act upon them in an intelligent manner at the next annual meeting.

As Dr. Eagleton says, we ought to know just what our Constitution and By-Laws are, and we have been delaying matters entirely too long; so I would suggest that the constitutional amendments read here today be published in the Journal and action thereon be taken at the next annual meeting and that the corrections in the By-Laws be adopted here today. We do not have to hold them up for another year. They can be acted on right here today. The changes proposed today are slight, but they do make the duties of the different organizations very much clearer than as they appeared in the By-Laws that were sent out.

Dr. Weeks: I second the motion that the report of the Committee on Revision of the Constitution and By-Laws be received and the recommendations acted upon, the subject matter to be continued in charge of the committee until completed.

President Hunter: For your information on this matter I will read Article XII: "Amendments. The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members present (not less than fifty) at any annual meeting, provided that such amendment shall have been submitted in writing at a previous annual meeting, and that it shall have been officially sent to each component society at least one month before the annual meeting at which final action is to be taken."

That covers your ground.

Dr. Gordon K. Dickinson: Mr. President, what can be done and what should be done are two different things. I think we all know that there are numerous members of the Society who have a sort of notion that the high-ups are a closed corporation. You want to do everything in corporation. We should do nothing which would in any way tend to accentuate the idea that the whole thing is being run by a

clique. I am strongly in favor of going slowly; I am strongly in favor of publishing these things in the Journal and taking one year or taking two years, but in any event taking long enough so that every man in the State will feel satisfied.

President Hunter: Are there any further remarks?

Dr. Johnson: I would like to say one word. We have worked upon this for a couple of years with the idea of getting it through. It was unfortunate that circumstances occurred as they did, and I think it is all right and must be done in the manner prescribed. In the meantime we are doing no harm; we have a Constitution and By-Laws that we have had for a good many years; they have worked all right during that period of time and they can continue working all right for another year.

Dr. Augustus J. Mitchell: Mr. Chairman, I desire to say this regarding the motion: I think we ought to go slow, as Dr. Eagleton has said. There are new things to be brought up continually; because we have had by-laws here and constitutions for the last one hundred years or more, I think we are in a more progressive age now and there are many things that can be remedied that would probably be of better service than some of the by-laws and constitutions that we have, that are one hundred or more years old, and it is for that reason that I still say we ought to go very slowly in changing these things, and let us talk them over and let the members of the State know before we go ahead and pass upon them.

The question was called for.

President Hunter: The question is that the recommendations of the Committee on the Revision of Constitution be received and their suggestions approved.

According to the Constitution, we have to lay that over for another year, and if some will include that in the motion we can proceed.

Dr. Henry B. Costill: I would suggest that these changes in the Constitution take the regular course.

Dr. George E. Reading: I move that this report be laid over for action until the next annual meeting.

President Hunter: Dr. Costill suggests that it follow the usual course, and I believe his suggestion covers that. All these changes must be published and officially sent to each component society a month before final action next year.

Dr. English: That meets it.

Dr. Schaffler: Mr. President, may I call attention to the fact that if this is laid over

for one year, then the final action will not be possible for two years. Therefore, it does not seem to me that it is very wise to lay it over.

President Hunter: We can act on it next year, according to the Constitution.

The question was called for.

President Hunter: Now then you are voting on the motion to lay over action on the amendments until next year.

Dr. English: Please understand that you are making a motion to lay over the constitutional amendments. The By-Laws should be adopted today.

President Hunter: We are not talking about the By-Laws now, we are talking about the Constitution.

President Hunter: The motion then means that we cannot adopt the report of the Committee on Revision of the Constitution, but continue the committee, that the changes in the Constitution be published in due time, according to the Constitution, and be acted upon at the next annual meeting.

All in favor will give their assent by saying "aye"; contrary? It is so ordered.

Now we will take up the question of the revision of the By-Laws.

Dr. Emanuel D. Newman: I move that they be adopted as published, with the amendment as offered by Dr. Johnson here today.

The motion was seconded by Dr. English and carried.

Dr. Chandler: That is not right. We should have these read twice.

Dr. Johnson: They were read twice last year.

Dr. Harvey: Mr. Chairman, I submit that the amendments that were read last year were adopted. These changes that they are making this year, if they go through in the regular form, should have more than one reading, but they can be amended on the third reading before this house.

President Hunter: They are not making any vital changes, Dr. Harvey, this year they are simply correcting the mistakes made in the wording of the last year's amendments.

The amendments were read twice and they have been adopted.

President Hunter: Now we will have the Report of the Judicial Council.

Dr. Conaway presented the Report of the Judicial Council.

REPORT OF JUDICIAL COUNCIL

It gives me great pleasure to present a report of the work performed by the Judicial Council of the New Jersey State Medical Society since June, 1922.

Four special meetings have been called and important matters relative to the work of our members freely and carefully discussed.

The Council notes with much regret a marked increase in the number of damage suits instituted against members of our Society. Of the many cases brought before us none were deemed of sufficient merit for us to withdraw the unanimous consent of the Council in their behalf.

Many of the cases were considered indeed very trifling, yet serious attempts had been made by laymen to coerce a physician or surgeon in good standing into making payments of a sum for the withdrawal of the threatened suit.

From my own district, which includes Atlantic, Cape May, Cumberland, Gloucester and Salem Counties, I am glad to report only threatened suit for damages. This case was not officially brought before the Council and I believe was settled out of court by advice of an insurance company.

It has been my pleasure to attend meetings at Atlantic, Cape May, Cumberland and Salem Counties and I regret my inability to visit Gloucester County. All the meetings at which I was present were well attended and the papers very interesting and instructive. The members were much interested in their work and very appreciative of the efforts of the visiting speakers.

The Council heartily endorses the suggestion that each member carry liability insurance of a sufficient amount to provide ample protection against suit for damages.

The reports from the first, second, third and fourth districts are herewith appended.

Respectfully submitted,

WALT P. CONAWAY,

Chairman.

Report of First District

It has been my pleasure to attend the meetings of the following Societies:

The Union County Medical Society on September 26, and on December 5, 1922—The latter to take under advisement the eligibility of Dr. I. A. Lawrence for reissuance of his license to practice medicine. It was unanimously determined that the sense of the meeting was against the reissuance of the license. I am enclosing a copy of the resolutions adopted by the Society in reference to Dr. Lawrence.

I take this opportunity of expressing my appreciation to the Union County Medical Society for their courtesy. It seems to me that the business of this Society is conducted along the lines of greatest benefits to the medical profession.

I also attended the meeting of the Warren County Medical Society held at Belvidere, N. J., on December 19, 1922.

I attended the meeting of the Morris County Medical Society held at Shonghum Sanatorium on May 29.

The business meeting of this Society was conducted with thoroughness and dispatch. The addresses delivered were of the best, and the Society is to be congratulated upon its methods.

The number of cases of suit, or threatened suit, for malpractice, in the First District, are as follows:

First.—That of Dr. Paul Livingston, of East

Orange, of which I attach a statement. This case has not come to trial, and Dr. Livingston informs me that he has heard nothing further from the people. It is his opinion, and mine, that the prompt action for defense taken by the Council was responsible for the case being dropped.

Second.—The case of Dr. Hunter Scott, of Newark.

I herewith enclose a copy of Dr. Scott's statement. Dr. Scott communicated with Mr. Wall, our attorney, who, Dr. Scott informs me, dictated a letter to the attorney employed by these people, and that so far nothing has been heard from them by either Dr. Scott, or Dr. Epstein who was the surgeon in the case.

Third.—The case of Dr. Ernest M. Lyon, of Newark.

You already have a copy of the statement made by Dr. Lyon concerning the treatment of Mrs. Ella Thomas. Dr. Lyon has informed me, within a month, that he has heard nothing further from these people regarding this case. Again the prompt action taken by the Council seems to have been sufficient to stop further threats of legal proceedings.

Fourth.—The case of Dr. Synnott, of Montclair.

You are already in possession of the complete and voluminous history and examinations of Dr. Synnott in the case of Mary E. Merrick. I will, therefore, not enclose them with this communication. Dr. Synnott has approached me within the last month with reference to a settlement in this case. My opinion in regard to this matter was expressed to you in a letter dated May 20.

Will you allow me before concluding this report to express a personal opinion which I feel sure is shared by every member of the Society. It is this: That the ease with which grounds can be found for bringing suits for malpractice against members of the medical profession is appalling. One has only to review the histories of the cases above mentioned to reach this conclusion.

Each case in which reasonable responsibility has been shown on the part of the doctor, that is fought to a finish by the Society, will supply the next man, and the Society as a whole, with additional armour of resistance in each succeeding case. No just man wishes to shield outrageous faults in another simply because that other is a member of his own profession—but that is not the type of case to which I refer—but to you, and to me, and to every man in the profession there must come a blush of shame that anyone with however little reason at his back, and no greater incentive than to avoid the payment of a just bill, can apparently find grounds for at least the endeavor to intimidate the best men in the profession. The men of our profession are giving a large part of their time to the care of the sick poor. The work without time limit during the best years of their lives—are called to answer the needs of any man at any time—and for the most part these calls never go unanswered. That men who are willing to do this should have hanging over their heads a sword in the shape of this type of blackmail is unjust and unfair, and it should be the endeavor of this Society, and every Society, to stop it insofar as their power lies. un

fortunately, members of the medical profession themselves are frequently responsible for some of the proceedings against their fellow practitioners. For example: Within the past year in our own hospital, a suit for malpractice was nearly precipitated by the statement of a doctor who was examining a ward case in consultation, and in the course of his conversation with other doctors let fall the remark that a previous operation was responsible for the present condition of the patient. A remark perfectly true in itself, but which, unfortunately, failed to carry with it the explanation that the previous operation was an absolute necessity; that it had been well done; and that the fault occasioned the complication lay with the patient and not with his caretakers.

While the Society as a whole may do much in presenting a bold and fearless front of defense in these cases, there is a certain responsibility which the doctor individually must take for himself, and a few duties, the performance of which are absolutely essential to the Society to enable it to fight successfully these cases. It has occurred to me that a few simple rules of conduct in every case might enable the man who has to fight for his reputation to put up a better defense:

1.—He should obtain a complete history in every case, with careful notes during its progress, including all laboratory and xray findings.

2.—He should, as far as possible, obtain releases in all operative work, or in cases requiring an anaesthetic.

3.—He should consult with other doctors in doubtful or unusual cases.

4.—He should state frankly the facts of the case, with exhibition of xray plates in all fracture cases, and if complete closed reduction is impossible, compel the patient with the xray plates before him to choose between the result obtained or voluntarily choose the open method.

5.—He should avoid all adverse criticism of another man's work, thereby lending his voice as a witness against that man.

6.—He should carry full Liability Insurance, and when unjustly assailed fight the case to a finish without settlement.

Signed,
MEFFORD RUNYON, Chm.

Report of Second District.

The only cases referred to me as Councillor of my District were those of Dr. Franklin J. Keller, 71 Ward street, Paterson, and Dr. Peter Brancato, 17 Church street, Paterson, which have both been reported to you in full under dates of November 18, 1922, and February 22, 1923, respectively.

Yours very truly,
HENRY SPENCE, Chm.

Report of Third District.

The third Judicial Council District comprises the counties of Mercer, Middlesex, Somerset, and Hunterdon, and each of the county societies in this group have held their meetings regularly during the past year and have had accessions to their membership.

I have been informed that the meetings were well attended and the papers were very instructive and well discussed.

I have visited each society except Middlesex, and on the date selected to go there was unavoidably detained by an emergency case.

We have been particularly fortunate in this Judicial District in being free from the annoyance, notoriety and expense to our members of having to defend any suits for so-called malpractice during the past year.

These suits which are so annoying to both the general practitioner and the specialist, seem to becoming more numerous each year since I have been a member of the council, and in nearly every case reflects no lack of skill or neglect on the part of the doctor, but rather a desire for easy money on the part of the clients, probably stimulated by some lawyer needing the case.

The proper solution of the case is plenty of insurance so every man is fully protected, and then fight every case to the finish; this the State Society can not afford to do for us, but it has provided the way for every member to secure protection at a very reasonable rate.

Each man should avail himself of this opportunity. By protecting yourself you are helping to keep this growing evil down.

EDWARD A. HAWKE, Chm.

Report of Fourth District.

The councilor of the Fourth District has very little to report. I have been unable to visit the component societies as I fully expected to do, owing to the condition of my health. After attending to my daily duties was compelled to rest.

I have, however, kept in touch with them; they report good attendance and excellent papers.

The only case brought to my attention for action by the councilors, was Dr. Wm. Schaffer of the Camden County Society. After our meeting in Newark, New Jersey, he acted on the advice given. Up until this time no further action has been taken by the one promising prosecution. I had a talk with him some days ago, and he wished me to thank the councilors for support given him.

I trust I may have the pleasure to meet with you at the annual gathering of the State Society.

Cordially yours,
HENRY H. DAVIS. Chm.

President Hunter: Gentlemen, you have heard the Report of the Judicial Council; what is your pleasure?

Dr. MacAlister: I move that it be received and spread upon the minutes.

The motion was regularly seconded and carried.

President Hunter: We now come to the Report of the Committee on Honorary Membership, Dr. Walter B. Johnson, Chairman.

Dr. Walter B. Johnson: The report of the Committee on Honorary Membership is that there is no candidate to present this year for honorary membership.

Dr. Sproul: I move that the report of the

Committee on Honorary Membership be received.

The motion was carried.

President Hunter: Now we come to the report of the Treasurer, Dr. Marsh.

Dr. Elias J. Marsh: Mr. President, the report for the year 1922 includes the supplementary report which was presented by Dr. Mercer last year and was published in the Journal as a supplementary report. The report for 1922 is as follows:

Treasurer's Report.
1922

| RECEIPTS. | | |
|---------------------------------------|-----------|-------------|
| Balance, Jan. 1..... | | \$805.00 |
| Dues— | | |
| Atlantic | \$ 848.00 | |
| Bergen | 736.00 | |
| Burlington | 328.00 | |
| Camden | 768.00 | |
| Cape May | 120.00 | |
| Cumberland | 384.00 | |
| Essex | 2,763.50 | |
| Gloucester | 216.00 | |
| Hudson | 1,508.00 | |
| Hunterdon | 16.00 | |
| Mercer | 104.00 | |
| Middlesex | 520.00 | |
| Monmouth | 411.00 | |
| Morris | 528.00 | |
| Ocean | 120.00 | |
| Passaic | 1,264.00 | |
| Salem | 200.00 | |
| Somerset | 299.00 | |
| Sussex | 144.00 | |
| Union | 1,320.00 | |
| Warren | 176.00 | |
| | | \$12,773.50 |
| Journal Receipts | | 4,067.49 |
| Exhibitors at annual meeting..... | | 716.60 |
| Interest on Invested Capital | | 190.00 |
| Interest on bank balances | | 104.45 |
| Refund of overpayment | | 8.55 |
| | | \$18,665.59 |
| Chicago and Alton, 3½% Bond, | | |
| 1m | | \$ 786.50 |
| U. S. 1st Liberty Loan, 3½%, 2m | | 2,000.00 |
| U. S. 4th Liberty Loan 4¼%, 2m | | 2,000.00 |
| | | \$4,786.50 |

1922
EXPENSES

| | |
|--------------------------------------|-------------|
| Committee on Arrangements | \$ 253.30 |
| “ “ By-Laws | 42.00 |
| “ “ Credentials | 213.04 |
| “ “ Program | 61.25 |
| “ “ Publication | 6,540.00 |
| “ “ Welfare | 4,008.84 |
| Judicial Council | 521.19 |
| Board of Trustees | 7.65 |
| Legal Expenses | 556.00 |
| Salaries and Expenses of Officers... | 1,404.95 |
| Printing and Stationery | 751.62 |
| Secretary's Office | 202.00 |
| Treasurer's Office | 73.20 |
| Balance | 4,030.55 |
| | <hr/> |
| | \$18,665.59 |

| | |
|---|----------|
| Chicago & Alton, 3 1/2 % Bd. 1m.... | \$786.50 |
| U. S. 1st Liberty Loan, 3 1/2 % Bd., 2m | 2,000.00 |
| U. S. 4th Liberty Loan, 4 1/4 % Bd. 2m | 2,000.00 |

\$4,786.50

E. J. Marsh, Treasurer.

Audited and found correct,

C. R. P. Fisher.

President Hunter: Gentlemen, you have heard the Report of the Treasurer; what is your pleasure?

Dr. Costill: I move that it be received and placed on file.

The motion was seconded by Dr. Weeks and carried.

Dr. Fisher: Mr. President, is this the proper time and place for the Auditing Committee to report?

President Hunter: I think this is the proper time and place.

Dr. Fisher: I so report, that the accounts are correct in every detail.

It was voted, upon motion of Dr. Weeks, regularly seconded, that the Report of the Auditing Committee be received and placed on file.

President Hunter: We now come to the report of the Committee on Prize Essay. The report was to have been presented by Dr. Marcy, but inasmuch as he is ill is there anybody here to report for him?

If not, we will pass on to the Report of the Committee on Public Hygiene and Sanitation, by Dr. Dickinson.

Dr. Dickinson: I am here by proxy. Since our committee has been hitched up to the State Medical Society and made its voice heard. Dr. Spence has done the work and it is his report that I am reading to you.

Dr. Dickinson presented the report.

Committee on Public Hygiene and Sanitation. Gentlemen:—

Your committee on Public Hygiene and Sanitation desire to report to you on matters of last year's Report, which were referred back to us for action:

1. Sanitary Districts — After conference with the State Department of Health, it was agreed that they would present Bills on this subject to the Legislature. Senate 207 and Assembly 257 were introduced and afterwards a Committee substitute was reported for the same. This substitute was worked out in great detail after a long and careful study, and would have passed had it been more thoroughly backed and introduced earlier. committee recommends that the society favor the introduction of these measures at the coming Legislature.

2.—Pasteurization of Milk—The State Department of Health did not attempt to re-introduce their Bill on Pasteurization of Milk this year, believing that the problem might be worked out in some other way and thus avoid the strong opposition which has always existed. Your committee recommends that our society

stand behind any plan that gives promise for a cleaner, purer and safer milk supply.

3.—Soft Drinks—Assembly No. 241 was introduced on this subject. A Committee substitute was introduced at the suggestion of the State Department of Health, but the Bill was defeated. We favor reintroduction of Bills along these lines for the next Legislature.

4.—Midwives—After a conference with your Welfare Committee, it was agreed that they would prepare and introduce amendments to the Midwifery Laws which would transfer the control of midwives from the State Board of Medical Examiners to the State Department of Health. Amendments were introduced in the form of Senate 262, 263 and 264. These Bills were defeated. While this seems to your committee an ideal plan of dealing with the subject, yet in view of the legislation that was enacted this year, namely, that of giving the State Board of Medical Examiners power to suspend midwives for violation of rules and the State Board of Medical Examiners and the State Department of Health are planning regulations, and also in view of the fact that to better co-operate along these lines, we do not recommend at present further legislation.

5.—Maternal Mortality—Your committee has, after study of the maternal mortality in New Jersey, become convinced that this subject is of such importance that a permanent committee from the State Society should be appointed to further investigate and report

6.—Sanitaria, Maternity Homes, Boarding Homes and Baby Farms—Were referred to the Committee on Hospital and Standardization.

7.—We recommend that legislation be introduced which removes the legal restriction which makes it unlawful for the local Boards of Health or the State Department of Health to disclose the names or addresses of persons reported to be affected with tuberculosis.

8.—We recommend that legislation be introduced that will remove the legal restriction which makes it unlawful for the State Department of Health to disclose the names and addresses of persons reported to be affected with contagious, infectious or communicable diseases.

9.—In the matter of annual fees for the licensing of midwives. It is our opinion that the collection of a fee for this purpose is wrong in principle and that the subject should be referred to the Welfare Committee with power to act.

President Hunter: Gentlemen, you have heard the Report of the Committee on Public Hygiene and Sanitation what is your pleasure?

Dr. Costill: I move that the report be received and filed, and the recommendations of the committee accepted.

The motion was seconded by Dr. Sproul.

Dr. Reddan: I did not hear just what that report was in reference to. Did it refer to reporting some classes of contagious diseases? May I ask what that was?

Dr. Dickinson: That there should be no restriction on giving names.

Dr. Reddan: To whom?

Dr. Dickinson: Ask Dr. Spence.

Dr. Reddan: The reason I am asking you this, Mr. President: So far as the restriction on giving out information in regard to syphilis, I have had this experience; that there is supposed to be an iron-bound rule of absolute secrecy. Yet I know of one man who lost his job where a case of syphilis had been reported to his employer before I got it at the State Laboratory. He lost his job before I got the official report at the State Laboratory, which is supposed to be absolutely official.

President Hunter: Gentlemen, are you ready for the question?

Dr. Reddan: Mr. President, I have not received any answer.

President Hunter: Dr. Spence, will you answer the question?

Dr. Henry Spence: This referred more particularly to contagious and infectious diseases. Tuberculosis is included in those. It is now impossible for the State Department of Health to furnish any local Board of Health with the names and addresses of people suffering from those diseases, and we think that that principle is wrong that local workers in public health should be supplied with all the information which the State has; and we have suggested that those changes be made.

President Hunter: Does that answer your question, Dr. Reddan?

Dr. Reddan: It does, yes sir. I don't know whether it is proper to discuss this report or whether it shall go on record as the will of the Society at this time.

President Hunter: Now is the time to discuss it before the question is put.

Dr. Reddan: It seems to me in the case I have just cited, that that will work a very great hardship upon a great many people. It is entirely a humanitarian proposition. Practically it is a proposition to get rid of the ill people in the factories and workshops; that is the ultimate result in a very great many of these uplift movements in many factories, ostensibly for the benefit of the workman; practically to get rid of him.

I think we ought to go very, very slowly in the action we take on making these things public property.

Dr. F. W. Pinneo: Mr. President, this question has been up before from a different angle. In the report of the Welfare Committee on the question of venereal disease control various views have been reported.

Would it not be advisable to state that the State Board can only release such information to the local Board of Health? It seems to me that the evils in the case

suggested could be guarded against if it were stated in the provision that this information could be released, but only given to the local Boards of Health.

Dr. English: Mr. President, I call attention to the fact that Dr. Spence has specifically stated that the information was to be given to the local Boards of Health, not to the public.

Dr. Fisher: Mr. President, I had an experience similar to the gentleman's down there, within the last two months, where a case of suspected tuberculosis in a music teacher was reported; a specimen of sputum was sent to the State Board of Health Laboratory, and almost before I knew it myself the people on the street in the whole borough where this teacher lived were discussing the fact that she had tuberculosis. I did not know she had it, but they knew it.

Dr. Ephraim R. Mulford: I have had very much the same kind of experience that Dr. Reddan has just here reported, and I think that this information should be very carefully guarded. I do not believe we are going to be able to get rid of our syphilitic and gonorrhitic cases if they are to be openly divulged. Anything that comes to our local Board of Health is open property and is permanent and can be seen. All the meetings of our local Board of Health are open meetings, open to the public, if they see fit to come. I think that information ought to be more carefully guarded than it has been.

Dr. Edward Guion: Mr. President, the last speaker is incorrect. The report on contagious diseases is not open to the public, and it should not be open to the public. If it were open to the public you would find some of these doctors would not report some of the diseases, and you would also find the patent medicine men would come to the Board of Health to get the lists of names of those who had these contagious diseases. I think it would be a great mistake to make the records open to the public.

Dr. Marcus W. Newcomb: Are we just safeguarding a few or are we safeguarding the public? I think that is the question. If we let these cases go wild in the factory we are going to get more infection.

Dr. Mulford: I think Dr. Newcomb is right, but to safeguard the public you have to safeguard the patients. If we are going to have these patients' names disclosed they won't come to the clinics, nor will they come to us. I have in mind two cases now that simply won't go anywhere.

Dr. Harvey: I think that this is the thing we have been struggling against—pater-

nalism. We have just lifted one corner of the tent, after some years, and it was especially urged upon us to support this measure of reporting these cases because the report would be considered confidential. Those of us who have watched the progress in this matter knew that the cry eventually would be for the free publication of these cases and I really feel that if we are going to open the door to the State government we ought to go right into State medicine.

I think this is a measure which is very assiduously breaking down the protection which has been the mainstay of the profession, and that is this: That we are not allowed to give information to anybody. I do not think that we should sustain this report or take the recommendations of this report regarding any more liberal legislation.

Dr. Berthold S. Pollak: Mr. President, I am particularly interested in this from the tuberculosis point of view. It seems to me that we are on the right track. I believe that we ought to endorse this. I believe the success in the tuberculosis movement has been largely due to the fact that we have been able to find our cases, and in finding the cases we have been able to do prophylactic work. We cannot find cases and do prophylactic work unless we know where tuberculosis exists. Therefore, we believe that the Tuberculosis Society of the Nation and of the State is in accord with the movement that has been introduced through Dr. Spence, that these cases be reported and that the reports of these patients be submitted through the health agents of the State, for without that, our function as a medical profession is not lived up to as it ought to be.

Dr. Dickinson: Mr. Chairman, the law of gravity saves millions of lives and breaks a few bones. Are we going to try and arrange with our practice of medicine to prevent a few bones being broken and subvert the law gravity? The great thing is to save people in the mass to relieve those who are distressed and prevent further contamination. If one or two people are going to feel offended because they are disturbed, are we going to listen to them and stop all our preventive work?

Dr. Spence: Mr. President, the State Department of Health is constantly being requested by local health workers, local Boards of Health, to furnish them with information regarding cases of tuberculosis, cases of typhoid fever, that have been reported to the State Department, and the State Department has always been compelled to inform them that legally they could not

transmit to them any of those names—and they can't.

Now it seems to be as a matter of principle, that that is wrong, absolutely wrong. What is the local health worker going to do if he does not know where his cases are? If the gentlemen here feel that venereal diseases should be made an exception, then let them introduce an amendment that they leave venereal diseases out of the contagious and infectious list. Then I think they can well accept the rest of them.

President Hunter: All in favor of receiving the Report of the Committee on Public Hygiene and Sanitation, placing it on file and acting on the recommendations afterwards, will give their consent by saying "aye"; contrary "no." It is so ordered.

President Hunter: We now come to the Report of the Committee on Public Health Education, by Dr. Marvel, which I am going to ask Dr. Costill to read.

Report of Committee on Public Health Education.

Your committee on Public Health Education begs to report that after much correspondence; in fact, after twenty communications had been sent, insisting upon a meeting with the National Educational Committee or the State Committee on Education, representing the National Educational Committee, an invitation was finally received through the State Superintendent of Education to meet the committee to discuss the School Health Program, at which meeting our president of the State Society, Dr. James Hunter, Jr., appeared with Dr. Harry W. Haight, a member of the committee, who, in the absence of the chairman and other members, represented the committee, with results in no wise particularly encouraging.

However, the evidence brought out at this meeting was sufficiently impressive in itself to establish the belief in the minds of the committee that a standard School Health Program is in great need in this State. Whether anything can be accomplished in this way or not is problematic and your committee feels that without greater encouragement on the part of the National Educational Committee their time and service is spent for naught. They would, therefore, recommend that this committee, for the present, at least, be discontinued.

Respectfully,

PHILIP MARVEL.

President Hunter: Gentlemen, you have heard the Report of the Committee and its recommendations.

Dr. Weeks: I move that the report be received and the recommendations adopted.

The motion was seconded and carried.

President Hunter: Now comes the Report of the Delegates to the American Medical Association and to State Societies.

Dr. Reading: Mr. President, as a delegate to the American Medical Association I found it was impossible for me to be present at the meeting of the Association, and on learning that Dr. Marvel, an alternate, would be able to be there, I constituted him as my alternate and Dr. Marvel is there at the present time.

President Hunter: Are there any other delegates' reports?

Now we come to the Report of Special Committees. I believe Dr. MacAlister has something to report.

Dr. MacAlister read the report.

Report of Budget Committee Committee of Arrangements

| | |
|-------------------------------------|-------------|
| By-Laws | \$ 42.00 |
| Credentials | 200.00 |
| Program | 65.00 |
| Publication | 6,540.00 |
| Welfare | 3,000.00 |
| Judicial Council | 525.00 |
| Board of Trustees | 10.00 |
| Legal Expenses | 500.00 |
| Salaries and Expenses of Officers.. | 1,404.00 |
| Printing and Stationary | 750.00 |
| Secretary's Office | 200.00 |
| Treasurer's Office | 75.00 |
| | <hr/> |
| | \$13,311.00 |

| | |
|-----------------------------------|-------------|
| Net Estimated Disbursements above | |
| Receipts for Dues this year..... | \$ 9,250.00 |
| Dues be made \$5.00 per capita | |
| bring about | 10,000.00 |
| Income About | 19,000.00 |
| Membership of 2,000. | |

Dr. English: I move that the report of the committee be accepted and approved and that the dues for the coming year be made five dollars.

The motion was carried.

President Hunter: We have a report from the Board of Medical Examiners.

Dr. MacAlister: Dr. Dickinson touched on some of the legislation that took place this winter and I wanted this opportunity to say something from the State Board of Medical Examiners concerning two or three bills that were introduced this year.

Dr. MacAlister presented the prepared report.

Chiropractic Bill.

Assembly Bill, No. 225, as it was first introduced provided that any person who was a graduate of a legally incorporated school, institute or college teaching chiropractic, requiring personal attendance, and who was actively engaged in the practice of chiropractic in New Jersey and a resident of New Jersey on July thirty-first, 1923, should upon filing proof thereof, be granted a limited license

for the purpose of practicing chiropractic in the State.

The board opposed this bill because the bill did not specify any length of study and continued to oppose the bill; however they were advised that there were sufficient votes to pass the bill, that if they wanted a course of study specified they could offer an amendment.

The board then attempted to have it amended to provide for at least three courses of six months each, but the only amendment that Mr. Harbourt would accept was one providing for two courses of six months each, and he would not accept one providing for an examination.

The board did not oppose the bill as amended in the Senate, providing for three courses of six months each and an examination before the board as they have felt from the time of the passage of Chapter 136, P. L. 1921, that would be necessary to provide some means by which those who had entered schools after the passage of the original Chiropractic Bill, and those that did not have time to take an examination before a Chiropractic Board should be given a chance to qualify. Our experience in the various courts in which prosecutions have been made, has confirmed our belief that this was the only wise course, as even the Judges have seemed to favor the defendants because of the fact that they were practicing when the law went into effect and were not given an opportunity to show whether they were qualified to practice.

These people have been given an opportunity, so that there can never be any question as to whether they were given fair treatment, we believe that the board should give those who failed a re-examination in October, not that they will probably be able to pass, but to settle that matter of fair treatment.

Of the 126 that took the examination, only 39 secured a passing average.

Appropriation Bill.

On December 22nd, 1921, the Board had a conference with the members of the Welfare Committee of the Medical Society, and the Legislative Committee of the Homeopathic Society, and at that time both the Welfare Committee and the Legislative Committee of the Homeopathic Society, pledged their support to any bill that the board might have prepared to secure funds for prosecutions. The board, with full remembrance of this pledge, had a supplement to the Medical Act prepared and introduced at the last session of the Legislature, this was known as Senate Bill 49, but before the bill was introduced the Board was advised that the Welfare Committee regarded it unwise to introduce the bill, therefore they did not give the support that they had previously pledged. However, the board felt justified in preceeding with the bill, because of the many complaints being received and because of the insistent requests from physicians all over the State for the prosecution of illegal practitioners.

The following is a report of what the board has been able to accomplish in regard to prosecutions, with the limited funds at their disposal for this work during the first six months of this year.

From Jan. 1, 1923, to June 15, 1923.

| Cases of violation of the Medical Practice Act : | |
|---|----|
| Cases won | 13 |
| Cases lost | 0 |
| Cases non-suited | 0 |
| Decisions withheld | 2 |
| Cases pending | 6 |
| Cases appealed (by defendant) | 1 |

—
22

Cases of Violation of **Midwifery Act**

| | |
|--------------------------|----|
| Cases won | 12 |
| Cases lost | 1 |
| Cases non-suited | 0 |
| Decisions withheld | 0 |
| Cases pending | 3 |

—
16

Cases of Violation of the **Chiropody Act**

| | |
|--|---|
| Cases won (settled without trial)..... | 4 |
| Cases lost | 0 |
| Cases pending | 1 |

—
5

Hearing Before the Board

Total Number of Cases Referred for Investi- gation and Prosecution

| | |
|--|----|
| Unlicensed Physicians and Osteopaths... | 24 |
| “ Chiropactors | 22 |
| “ Chiropodists | 10 |
| “ Midwives | 52 |
| Midwives practicing medicine | 1 |
| Electro-therapists—unlicensed | 3 |
| Druggists practicing medicine | 4 |
| Beauty parlors | 4 |
| Midwives referred for collection and pen- alty for non-registration | 22 |
| Chiropodists referred for prosecution for non-registration | 7 |
| Midwives referred for revocation of li- cense | 4 |
| Physicians referred for revocation of li- cense | 2 |
| Unclassified practicing medicine | 12 |
| Unclassified investigations | 8 |

*175

*A total of seven cases over the total for entire year of 1922.

Midwifery Bill.

During the session of the Legislature, several bills were introduced, which if passed would have taken from the board the power to license the midwives, and given it to the State Department of Health. This would have been the first split in the composite board we now have in this State and an argument for the osteopaths and chiropractors on their efforts to secure a separate board. It would have taken from the board one of the principles sources of income and still further hindered the board in their efforts to comply with the demand of the profession in general for the prosecution of illegal practitioners. This bill was defeated through the efforts of the board.

The Board had the Midwifery Act amended to permit them to accept midwives who had completed a nine months' resident course in the Bellevue Maternity Hospital, as well as a two-year non-resident course in the Newark Maternity Hospital. The nine month resident, and the two-year non-resident course covers the same number of hours instruction in mid-

wifery. The Act was also amended to permit the board to suspend as well as revoke licenses. The board each year hears a number of cases in which they do not consider the evidence sufficient to warrant revocation of a license, but in which they do believe a suspension would be warranted, as the midwife has been negligent.

Another reason why the Board believes that the midwives should not be removed from their jurisdiction is that the Board of Healths, through its division of Child Hygiene has the supervision of the midwives, and the majority of the complaints and requests for the revocation of licenses come from this department, based on a report made by the supervisor, therefore, if these cases were heard by the Board of Health, they would naturally be prejudiced, whereas, the Board is not prejudiced and we believe that for this reason they are in position to judge the case on its merits and give a fair decision.

Co-operation Between Society and Board.

The board believes that there should be greater co-operation between the board and the various societies in this State, and they have at times endeavored to bring this about by inviting the committees of the various societies to meet with them and discuss pending legislation, feeling that experience gained through many years of administration should be of value to the profession. On January 30, 1923, they addressed a letter to the Chairman of the Welfare Committee of the Medical Society stating that they would hold a meeting on February 6, 1923, at which time the Legislative Committee of the Homeopathic Society would be present and asking the Chairman to notify the members of the Welfare Committee. At that meeting the Welfare Committee had one member present, and as far as could be determined, the invitation was not extended to the committee as a whole.

Endorsements.

At the meeting of the Society last year it was stated that the board admits a great many more by endorsements than by examination in this state, and the conclusion drawn that the board admits men to practice in this State by endorsement that could not be admitted to examination.

During the year of 1921, which is similar to any other year, the board endorsed one hundred and twenty licenses from other states, sixty of that number were from New York, fifteen from Pennsylvania, so that the majority of those endorsed were from neighboring states in which are located medical colleges and large hospitals, and states in which the standard for licensure is equal to that of New Jersey. But in every instance, whether the applicant came from New York, Pennsylvania, or some other state, he met the same requirements in the state in which he was examined as were in effect in this state at the time he was licensed in the foreign state, and that is all that our law asks an applicant to do.

In looking for a reason why more men should apply for endorsement than for examination the board found that the majority of their applicants had taken the examination in the state in which they served their internship, or had selected a state which reciprocated with the greatest number of other states.

The board also believes that another reason which contributes to the larger number of endorsements, as compared with those of ten years ago, is that other states have raised their standards making it possible for New Jersey to endorse their licenses, which could not be done ten years ago.

Standards.

The board in a recent survey of the medical laws of other states found that standard of 37 of the states in regard to premedical and medical education was equivalent to the standards of New Jersey.

Organization of Boards.

In the recent survey made, the board found that in two states where the State Board of Health had charge of examining and licensing physicians, one found it satisfactory and the other unsatisfactory.

In the states where there is a composite board, similar to the board in New Jersey, 24 states found it satisfactory and one not entirely satisfactory.

In Illinois where there is a department in charge of all professions and the head changes with the change of administration, there had been a recent scandal, and practically all states that refused to endorse licentiates of Illinois during that period. We are sure that this is an experience that physicians taking the examination in this state would want to avoid, and while such a department may operate well with the right person in charge, it will always be a political department.

The present law preserves to the medical profession its identity and makes it possible for the profession to obtain a hearing on matters of public health. The mixed personnel of the board affords opportunity for discussion and co-operation of the various medical organizations. The department has an excellent system of records and the long length of service of some of the members has resulted in the continuity of policy in the enforcement of requirements that we do not believe could result should the department be merely a cog in the wheel, such as the medical boards in states in which a department licenses all professions.

The penalty section of our present Medical Act has made possible successful prosecutions of the fighting chiropractors. This is possible because a fine is the penalty and the courts have final jurisdiction, no jury being allowed. The best law that can be written is utterly worthless in the matter of enforcement against illegal practitioners unless its penalty section provides for rapid and repeated prosecutions. In most of the states it takes two or three years to make a conviction stick if there is organized opposition. In New Jersey, if the board was supplied with sufficient funds to do so, the board could in case of an appeal and the offender attempted to practice immediately prepare another action against the offender. We believe this would be an effective way of endorsement and that we could in this manner clean house, and at the same time obtain an educated type of practitioners whether he be physician or cytist. We will then have protected the public from incompetency and that after all is the only reason any law governing medical practice has ever enacted.

The recent survey also showed that in the

states where prosecutions are had through the prosecutor of county, or the district attorney, the method was satisfactory in five states, fairly satisfactory in one more if the board assisted the prosecutor and unsatisfactory in sixteen states. This is the method provided by New York law and the New York board has the following to say in regards to it: "Prosecution should be by the Attorney General upon evidence collected by investigators especially appointed for this purpose." This is the same method that we now have.

In fifteen states that have a prosecution clause in their medical act similar to that in the New Jersey law, all found the method satisfactory.

President Hunter: Gentlemen, what will you do with Dr. MacAlister's report?

Dr. Schauffler: I move that it be accepted and placed on file.

The motion was regularly seconded.

President Hunter: Is there any discussion?

Dr. MacAlister: Mr. President, there is just one remark I wanted to make. If the State Board of Medical Examiners had a registration clause we could take care of all these prosecutions. Of course we haven't it and they are not willing to have it.

Now I want to make another proposition: If you will give the State Board of Medical Examiners the same amount of money that the Legislative Committee spends we will watch the State Board of Health and safeguard the privileges.

Dr. Newman: Why should the doctors pay to have our laws enforced? Why should they pay to have any prosecutions? Why ask us to pay extra for that purpose? The Welfare Committee is an entirely different proposition. I think that the proposition is all wrong.

President Hunter: I think the question is well taken. Are there any other remarks?

Dr. Eagleton: I did not hear the first part of this gentleman's report, Mr. President, but I just want to call attention to the fact that he said so far as he knows, while a member of the Welfare Committee, none of the rest were invited. We received an invitation from the Board of Medical Directors to meet in Trenton. We welcomed that and we sent a representative. Certainly the Welfare Committee did not feel that it should call its twenty-one members to come down and talk with the State Board of Medical Examiners. On the other hand, when the Welfare Committee has had anything to do with the matters pertaining to the State Board of Medical Examiners, an invitation has been extended to the State Board of Medical Examiners to come to Newark. We are always glad to receive

their invitations. They receive our invitations but do not come.

It seems to me that the attitude just expressed by Dr. MacAlister here shows the weakness of our profession. The Welfare Committee is not representing anybody in particular; it is representing the medical profession. The State Board of Medical Examiners are not representing anybody in particular; they are representing the public and the State. There must be cooperation between us.

The State Society, however, would make a great mistake if it got into its head that the State Board of Medical Examiners should simply represent them. One of the great weaknesses that we meet in Trenton is that we are all the time spoken of as if we were a trust and as if the State Board of Medical Examiners were a part of the trust. That is not so. If we doctors are so foolish as to contribute money to the State Board of Medical Examiners, operating for the State, then everybody will say that is so. As doctors we should not contribute one cent. It is beneath our dignity! For the Secretary of the State Board of Medical Examiners to ask an appropriation of money for them, a State Board, to function, is against good ethics. It would defeat the very object that it has in view. For them to ask for an annual registration of doctors to enforce the law, to drive out the illegal practitioners, is worse ethics. We would be placing in the hands of our men who do not approve of any law, the argument that the State Board of Medical Examiners was simply an arm of us, and that we were using that arm to oppress them. Have you ever thought what annual registration could mean under a corrupt board, not under this board as at present constituted? A Board which is political—and it must be more or less political if the Governor or the powers that be appoint it—could say to any man, "Well, you talk too much, or you do too much" when annual registration came around some little thing could be found and perhaps it would be held up.

We have worked by education, by qualifications to be licensed by the State. As long as I have a voice I shall be opposed to placing in the hands of any board the right to relicense any physician, although I believe that the board should rigidly enforce, and when we as physicians are derelict in our duty or guilty of something against the public health, they should be courageous in revoking our license; not reregistering it.

Dr. MacAlister: In answer to Dr. Eagleton, he has an idea, as a good many mem-

bers have, that if we had an annual registration we probably would revoke a man's license because he wouldn't register. There is nothing to that at all. As an example, I want to say that the Dental Board in this State has an annual registration and uses those funds for the prosecution of cases. Of course, it is a board that has no annual appropriation from the State and it has to use those moneys that are collected for annual registration and other things. Also the State Board of Pharmacy and the Chiropractists are under the same category, and there does not seem to be any trouble about those people having sufficient funds to prosecute their cases.

President Hunter: Gentlemen, the whole proposition is just as Dr. Eagleton has put it to you. We have confused too long the responsibility of this organization as an organization in reference to the responsibilities of the public at large. The responsibilities for the functioning of the State Board belong to the public; should be met by the public, and paid for by the public, not by this profession.

Are you ready for the question?

Dr. Reading: I am not quite ready for the question. I was, until the President made his remarks just now. The only fault that we, as a State Medical Board, have to find is that when we ask the Welfare Committee of this Society to help us get an appropriation so that the State would pay for its own work, they say, "We are sorry but we cannot support you." That was the trouble that we had with the State Welfare Committee last winter. Not that we wanted this Society to give us their money; not that we wanted the members of the medical profession to pay for something that the State ought to pay for, but when our Board went to the State Legislature and asked them to appropriate some money to us so we could prosecute these cases, and we asked the Welfare Committee as a committee that is supposed to have all medical things in their charge and to help along such things as are right and proper in a medical way, after once promising that they would support us, when it came to a pinch, they said, "We are sorry but we have some reason or other why we cannot support you." The thing consequently fell through. That is what we are objecting to, and that is the only objection we have to anything the Welfare Committee or this Society has done.

We do not ask the Society to give their money. I do not think Dr. MacAlister had any idea of asking for an appropriation from this Society. When he said, "Give as

much money as they had," he meant, give it to us in the right way; give it to us from the State in the right way, in the way it ought to come. We ought not to be made to fall down in our prosecution for lack of funds because the State won't give us anything and when we ask for an appropriation, any medical body, any association that has a welfare committee or a legislative committee ought to help us to get it, and get the money from the State, where it should come from, and where we want it to come from.

Dr. Sidney C. Keller: Mr. President, I would like to ask the preceding speaker what the Attorney General's office of Trenton is for? What need is there for this appropriation to prosecute these cases? Surely if there is any case that requires prosecution by the State Board the Attorney General's office is maintained for that purpose, and I fail to understand why any appropriation should be made.

Dr. Jesse D. Lippincott: Mr. President, that was the very position that the Welfare Committee took at the time the State Board representative was before us: That it was not a case of the doctors' or a special appropriation for this work, but that these prosecutions should come in the regular way, the same as any other infraction of the law. That was the position they took. It wasn't that they did not want to give the State Board any money, but it was the purpose of the money.

Dr. Newman: I would like to ask a question: Will members of the State Board of Examiners kindly inform me to whom they make a report? Do they make a financial report to us here? Do they make it to the doctors? Do they make it to the State?

Dr. MacAlister: They make it to the State annually. It is a matter of public record.

Dr. Newman: We don't know anything about it, do we?

The question was called for.

Dr. James J. McGuire: I have been a member of this Board for several years. I had the honor of being elected President of the State Board of Medical Examiners two years ago. We had been severely criticized from one end of the State to the other because we did not prosecute irregular practitioners. There is a certain amount of money which comes in to the State Board.

Dr. Newman: How much money comes in to that Board?

Dr. McGuire: Dr. MacAlister can tell you how much.

When I was elected President I asked the members of the Welfare Committee to meet with us to thrash this thing out. We had a meeting at that time and the Welfare Committee signified their intention; everybody was waving the flag—"We will do everything we can to back you up, to get money to prosecute the irregular practitioners."

At the meeting last fall, when they took an entirely different attitude, I was not present. I am also a member of this Welfare Committee.

Dr. Eagleton: You were notified of every meeting, so that the State Board of Medical Examiners would know what we were doing.

Dr. McGuire: If we are to prosecute the irregular practitioners it takes money, and unless we get some money through the State to prosecute them, we are not going to get anywhere at all. We have these cases reported to us and we report them to the Attorney General's office and they do not move at all unless we have the means to proceed against them. Unless we can get some money to prosecute the cases we are never going to prosecute any of them at all.

Dr. MacAlister: The answer to the question about the money that comes in to the Board is that it is in the neighborhood of \$20,000, and about \$18,000 of that is spent for prosecutions and the remainder for the upkeep of the Board. We are up on our prosecutions perhaps fifty per cent. That amount does not nearly cover the expense I receive every day from one to four complaints; every day people complain and want to know why we do not prosecute cases. We prosecute all the cases we can, up to the limit, and that is the best we can do.

Dr. Eagleton: The Secretary has made two statements. One is that if this Society gives as much to the work as it gives to the Welfare Committee they would clean up the State. The other is that they have \$20,000 coming in to the Board, of which \$18,000 is spent for prosecutions. The Welfare Committee last year cost you \$2,700. They want \$2,700 more out of the Society to clean up the State. They have \$18,000. Now there are \$30,000 to distribute. We are not criticizing; I don't want anybody to understand here that the Welfare Committee is criticizing the State Board of Medical Examiners. We are trying to cooperate, but we are trying also to preserve the dignity of the profession as a whole.

Dr. Reading complained that we refused

to give them support in connection with their appropriation bill. We frankly told them that in our judgment it would be a mistake for the Welfare Committee of the State Medical Society to go on record as trying to get this money from the public because it would defeat the very object for which the money was to be appropriated; that the public should appropriate this money, not entirely by the assistance of the doctors, because then the same thing would happen as happened in California. When this scheme was proposed we were in favor of it. We said, "We will get behind you and get you the \$10,000." Then the Welfare Committee was in correspondence with many other States, among which was California, and we found this was what happened: In California they have a strong State Board of Medical Examiners; they represent the profession. They began cleaning up the State, and the chiropractors began going to jail, and when they came out of jail they were martyrs. I received a letter from one of the officers of the A. M. A. saying, "Do as California is doing. They have got the dope!" I was very much impressed.

Then the chiropractors and the osteopaths got together and put on a campaign to show the oppressive methods of the State Board of Medical Examiners of California, and they asked for a referendum and I was told that the State would be swept in favor of the medical profession. When the election came the medical profession was swamped, and as a result of this election California today is operating under three boards: The Chiropractic Board, the Medical Board and the Osteopathic Board.

In view of that fact we said the State Welfare Committee would keep its hands off. If the State Board of Medical Examiners can get \$10,000 or \$1,000,000 God bless them; we would never interfere by word nor act when we asked if we were in favor of it we would say it was a fine thing but we refused in the name of the profession to have this appropriation stamped as entirely a medical matter, and we did keep our hands off. That is the reason we did.

Dr. English: Mr. President, I would like to ask a question: Do I understand that when the State Board of Medical Examiners reports a case of violation of law to the Attorney General of this State that he won't proceed unless he knows that the Board of Medical Examiners has money enough to prosecute it?

Dr. MacAlister: He will prosecute the

case and the costs have to be borne by the State Board of Medical Examiners. To illustrate how much it costs: I was in Trenton yesterday and we had a case that had been postponed about two months ago and the costs in that case were about eighty or ninety dollars. The case was to come upon the twentieth of this month again, and they wanted to postpone the case again. If that case were postponed again the State Board of Medical Examiners would be put to the expense of ninety dollars more.

That is just the way some of our money goes, over which we have no control; and the Attorney General's office will permit those things to happen.

President Hunter: Gentlemen, the hour is getting late and I think we ought to take a vote on this proposition.

It has been moved and seconded that the report of Dr. MacAlister be accepted and placed on file. All those in favor of the motion will give their assent by saying "aye;" contrary, "no." The motion is carried.

We have just five minutes left and I think Dr. Costill can give us the report of Dr. McCoy, Chairman of the Standardization Committee.

Dr. Costill: Dr. McCoy, the Chairman of this committee, could not be present at this meeting, inasmuch as he has gone to the meeting of the A. M. A. and he sent the report to me and requested me to read it.

Dr. Costill presented the report.

Report of The Hospital Standardization Committee.

Last fall the New Jersey Welfare Committee was requested to meet with the representatives of the Nursing Associations of the State, relative to legislative matters pertaining to nursing. It was deemed best by the Welfare Committee, that matters relative to nursing, inasmuch, as it was so intimately correlated with hospital work, should be referred to the Hospital Standardization Committee. The Hospital Standardization Committee had brought to its attention, through its association with the hospitals, the fact that there was a marked shortage of nurses, not only in the hospitals of the State, but also in the communities in which these hospitals were located, there existed a shortage of nurses for private practice. The State Welfare Committee also requested the Hospital Standardization Committee to consider the problem of the shortage of nurses in the State, and particularly to take up the matter of the trained attendant, and the establishment of a group of nurses, which should be subsidiary to the regular R. N. Nurse.

During the year numerous conferences have been held by the Hospital Standardization Committee with the various Nursing Associations and organizations in the State. While at first there seemed to be a spirit of antagon-

ism, which was evidenced not only by the nursing profession, but also by the medical profession, in regard to a subsidiary group of nurses. As time went on, and each of the professions interested looked at the matter more from the standpoint of the hospital and the patient, than from that of their individual organizations, the atmosphere became clarified, and each realized that they had the same object in view, namely, the best interest of the institutions, the patients and the communities in which they were working.

There seemed to be in the beginning an idea prevalent that it was the purpose of the medical profession to lower the standard of the nursing profession, so far as educational requirements were concerned. At no time has and such idea prevailed. As we view the situation to day, it is perfectly apparent that with the many new avenues of work open to the nursing profession, and if we are to have in the community a group of subsidiary attendants or nurses, it behooves us to maintain the educational standard of the trained nurse not only as they are today, but even higher.

With the demand made upon trained nurses such as Social Service Work, Child Welfare, Hospital Instructors, it is obvious that we must have women with higher education, rather than less education. It is my own opinion that every applicant applying for training in a recognized hospital, anticipating a R. N. Degree, should enter her training with at least a full high school education. If the subsidiary nursing group is established in the State, it will be necessary to have a large number of instructors for these women, these must come from the ranks of the trained nurse. I believe that no nurse should be employed in the capacity of a teacher for training school work unless she has had at least a full four years' high school education.

In the evolution of our training schools it has been the custom to employ an itinerant teacher, who travels from school to school in a perfunctory manner giving certain set courses in each school. I believe that this militates against good work, and I feel that in each individual school of nursing only such women should be employed as Superintendent, Assistant Superintendent, Operating Room Nurse, Charge Nurses, who will be able to assume full charge in carrying out the teaching curriculum of the school. This brings the teacher in intimate contact, not only in didactic work, but also in the carrying out of that far more important problem of practical demonstrations in the hospital, which is the end result of her teaching.

Your committee also attended a meeting in Philadelphia February 28th, 1923, upon the subject "The Nursing Problem in Philadelphia."

As a result of the numerous conferences a meeting was held in Newark during March, to which were invited: 1—Representatives of the Board of Managers of the Hospitals of the State. 2—Nurses and other laymen interested in the Hospital and Nursing Problems on the State. 3—Hospital Standardization Committee. Previous to this meeting a questionnaire had been submitted to each of the hospitals of the State, relative to the Nursing Problem

presented not only in the individual hospital, but in the community in which the hospital was located. This questionnaire endeavored to elicit the shortage of pupil nurses, and probationers, the difficulty in procuring desirable applicants, and whether there was a shortage of nurses in the community, and the attitude of the hospital relative to the establishment of a course for trained attendants.

Without going into detail, from the hospitals which replied to the questionnaire, it was apparent that there was a material shortage of applicants for nursing in the various hospitals, also that there existed a shortage of nurses for private practice in every community heard from, that there was a large number of the population in every community unable to meet the financial burden placed upon them by employing trained nurses in private practice, that there was a marked inclination on the part of the nursing profession, evidencing an emphatic preference for nursing in institutions, thus accounting for part of the shortage of private nurses.

The replies to the questionnaire submitted formed the basis of the discussion for the Newark meeting. At this meeting which was largely attended, and after free discussion by the members of the Board of Managers, physicians and nurses, the following resolutions were unanimously adopted: 1—That there is acknowledged to be a shortage of nurses in New Jersey, and that it is advisable to consider ways and means, whereby a second type of nurse may be developed in addition to the R. N. Nurse in this State.

2—That a committee of nine be appointed to consist of three members from the Board of Managers of the hospital; three members of the Hospital Standardization Committee, and three members of the Nurses' Association which committee should consider ways and means of adopting a course of training for the education of a subsidiary group of nurses for the State, and after they have formulated a plan, they should submit the same to their different groups for their approval, and then report to a meeting of the whole. This committee has been considering the problem from various angles, and to those conversant with the conditions in other states, it is readily appreciable that a considerable amount of work must be done before a definite form of action may be recommended. Up to the present time investigations of the committee have led to the conclusion that a subsidiary group of nurses is necessary in this State. The committee is in accord with the fact that a one-year course of training should be established, and that this course of training shall extend over a period of one year, it shall be open to women of good reputation with limited education requirements, with an age limit of 17 to 45. The committee is of the opinion that the training of this group of nurses or attendants shall be entirely separate from that of the students pursuing the R. N. Course, that they shall not be associated in the same home, taught in the same classes, or associated as equals in their practical hospital work. In brief there should be an emphatic distinction between the subsidiary group and the

regular trained nurse. The committee is also of the opinion that there should be legislative enactment governing the trained attendant, that when she qualifies after her year's work, the State shall issue to her a license as a trained attendant, which license shall be renewed each year at a minimum fee. As to the curriculum or course of training for such attendants, we feel that it should be equivalent to one year's practical training in a recognized hospital. On this basis the curriculum would have more or less latitude and could be adapted to individual communities. In large centers of population where there exists an Almshouse, Isolation Hospital, and various Social Service Centres, such as Child Welfare, Milk Stations, and well-established municipal Boards of Health, it would be perfectly feasible for a woman to receive three months of her training in an Isolation Hospital or Almshouse, three months in association with the Child Welfare and Milk Station Nurse and School Nurses, then three months in a hospital working under and being taught by a regular nurse, and her last three months could readily be spent by being assigned from the central bureau to private nursing in the community under the supervision and direction of a regular trained nurse. As to the number of these aids which could be assigned to a hospital, it has been considered that a number equal to fifty per cent. of their full quota of nurses will be appropriate.

At the present time it would seem that there are two classes in the community, who are properly provided for, so far as medical attention and nursing is concerned, namely, the well to do and the very poor. The burden seems to fall upon those of limited means. We believe that a good proportion of the sick may be cared for by one less trained than the woman who has devoted three years and acquiring the degree of R. N., and it does not seem economically or socially correct that a woman with this training should devote herself exclusively to the care of an individual patient, except during the period of acute illness when keen observation and a well-trained mind is demanded. The work during the period of convalescence, should be taken up by one of less experience, thus leaving a large number of well trained, well educated, capable women free for institutional and teaching positions and social service work. The problem is a large one. It is both national and local, and can be solved only by co-operation of all those interested. As one has said, "Nursing is now a profession. Comparatively few nurses become mercenary, and not more so than doctors. The conduct of a few should not prejudice one against an entire group. The present is a transition period. Fewer doctors are being graduated yearly, so that, medical service is as unavailable as nursing care."

There is at present time in the U. S. almost as many practical nurses as trained nurses. Would it not be better to guide and direct this class of women, raise their standard, bring them under state control, and is it not time, that we recognize the difference between the highly specialized nurse and the duty she is called upon to perform, and establish another class, which will have to do with the mechanical part of nursing. With this in view the

pupil endeavoring to obtain her degree of R. N. should in no manner be a financial asset to the hospital. The training school should be looked upon just as much as a part of our educational system as the high school, and we approve of the change of the nomenclature of the nurse's act designating such training schools as schools of nursing.

The committee wishes to thank the Nurses Associations, Board of Managers and laymen who have co-operated in the discussion of this problem during the past year, and we trust that we will be able to submit a definite outline to a con-joint meeting of those interested in the near future.

The Hospital Standardization Committee, during part of the year, by the death of Dr. Grier of Elizabeth, has been deprived of the counsel and advice of one of our most respected members.

JOHN C. MCCOY, Chm.

Dr. MacAlister: I move that the report be received and placed on file.

The motion was regularly seconded and carried.

President Hunter: Each member of the Nominating Committee should present to the Recording Secretary his certificate before the opening of the afternoon session so that the names of the Nominating Committee may be announced as indicated on the program. The Nominating Committee will meet at 5:30 p. m. in the committee room.

Dr. English: I would like to give notice that the Fellows will meet immediately after this meeting in this room to elect five delegates on the Nominating Committee.

Dr. Schauffler: I move that we adjourn.

The motion was seconded by Dr. Johnson and carried and the meeting adjourned at twelve-thirty o'clock.

Meeting of House of Delegates.

THURSDAY AFTERNOON SESSION,

June 21, 1923.

President Hunter: The meeting will come to order. The first item is Unfinished Business. Under that heading come the Reports on Nominees for Permanent Delegates, on Permanent Delegates, and Election of Permanent Delegates. Is the data in? Is the Secretary here? (There was no response.)

We will not hold up the meeting, but will go on to the next item and return to that later.

The next item is the Report of the Business Committee.

Dr. Weeks: Nothing has been referred to the Business Committee, Mr. President.

President Hunter: Miscellaneous Business. Is there anything under that head to be taken up at this time?

Dr. Dickinson: My attention has been

called to the fact that several of our members are seriously ill. Dr. Iszard and Dr. Mercer are both ill. Dr. Iszard is the oldest practitioner in the State connected with this Society. Dr. Mercer is one of our Vice-Presidents. I am also informed that Dr. Marcy is ill. Therefore, I would move that resolutions of condolence be sent to our sick members at once.

The motion was regularly seconded and carried.

President Hunter: Report on Permanent Delegates. Dr. Chandler.

Dr. Chandler presented the report.

Report on Permanent Delegates.

Last year our permanent delegateship numbered 145. We elected quite a large number of new delegates and we have this year on our lists the number of 180. We have lost by death, eight—Edward Field, of Red Bank; James M. Reese, of Phillipsburg; William S. Disbrow and Theodor Y. Sutphen, of Newark; William F. Faison, of Jersey City; James Douglass, of Morristown, and Edgar B. Grier, of Elizabeth.

This is not the regular year for filling quotas, but we have a number of candidates to fill vacancies made by death.

The following candidates have been presented for election today and the ballot will be taken at the time set therefor on the program: Morris County, Clifford Mills, Morristown; Union County, Horace R. Livingood, Elizabeth.

The following have been absent from the meetings of the Society for two successive years without excuse satisfactory to the Council. Unless such excuse is presented and accepted their names will hereafter be dropped from the roll of Permanent Delegates: Alvah A. Swaze, James W. Croctor, J. Morgan Dix, Chas. H. Finke, John G. Wilson, Daniel E. Roberts, Ralph R. Jones, Josiah Meigh, George R. Kent, Geo. A. Vanwegenen, Chas. F. U. Underwood, David E. English, Geo. B. Philhower, W. S. Disbrow, H. J. F. Wallhauser and Francis H. Todd.

All excuses for absences must be presented to the Councillors in writing.

David F. Weeks, R. H. M. Davis.

Dr. Chandler: If these gentlemen have any excuses to present, they should send them to the Council, who take cognizance of all excuses offered by permanent delegates.

President Hunter: Gentlemen, you have heard the report of the Recording Secretary on the Permanent Delegates; what is your pleasure?

Dr. Sproul: I move that the report be received and placed on file.

The motion was regularly seconded and carried.

President Hunter: Now comes the election of Permanent Delegates.

Dr. Chandler: These names are all that I have. If there are any other candidates

that have been presented I wish that the counties from which they come would send me their names so that they may be proposed for election.

Dr. Davis: Mr. President, my name was presented before the annual meeting of last year, 1922. The Secretary thought there was some error in making out the credentials but I believe there was an agreement reached by the councillors at that meeting that I should be given a seat, and I was given a seat, but my name was not mentioned in the report. I tried to correct the error in the report.

Dr. Chandler: Dr. Davis has been regularly nominated by his Society.

Dr. Weeks: I am in that same position.

Dr. Chandler: Dr. David F. Weeks was proposed here last year but his name did not appear in the records. However, it should appear.

President Hunter: Have any other names of permanent delegates been missed? If not, we will go into the election of Permanent Delegates.

Dr. Sproul: I move, Mr. President, that the Secretary cast one ballot for the candidates named.

The motion was carried.

President Hunter: The Secretary will cast the ballot.

Dr. Chandler: I have cast the ballot.

President Hunter: I declare these gentlemen duly elected.

Is there any other unfinished business to come before the Society at this time? If not we will go to the Report of the Business Committee. There is no report, Dr. Weeks.

Miscellaneous Business is next.

Dr. Chandler: I have reported here that the Fellows nominated for the Nominating Committee are Drs. Costill, Ill, Sproul and English.

I have the resignation of Dr. Kane from the Scientific Committee. Dr. Kane requested to have his resignation presented here and I take this opportunity of presenting his resignation as a member of the Scientific Committee, and the Nominating Committee will bear that in mind when they bring in their report.

There is one other thing that I want to speak of. I have been Secretary of this Society for many years but I feel that the time has come when I should tender my resignation, and I wish to do that here today before the Nominating Committee has taken any action.

It has always been a pleasure to me to do this work, but I desire that the Society

shall at this time accept my resignation as Secretary of this Society.

President Hunter: Gentlemen, I need hardly say to you a word as to the faithfulness and the years of service that have been given to us by Dr. Chandler. I feel that at this time some motion is in order of a complimentary character for the long years of faithful service that Dr. Chandler has rendered to the Medical Society of New Jersey.

Dr. Newman: Mr. President, I regret that the representative from Essex County is not present, but at a caucus of the Essex County delegates we learned with regret that Dr. Chandler was going to take this step and a resolution was adopted, and I would suggest that we adopt the following:

Our honored Recording Secretary has for twenty-six years held this office—except during an interim when Vice-President and President of the State Society—and always with a devotion and attention to detail which is indispensable in the great labor of this office. To honor such a faithful officer we move that Dr. William J. Chandler be elected by the House of Delegates an honorary member of the State Society.

As I understand it, there was but one member of this Society before so honored, and that was Dr. Wickes, I believe.

I would offer that resolution, Mr. President, and have the same referred to the Committee on Honorary Membership. I put that in the form of a motion.

The motion was seconded by Dr. MacAlister.

Dr. English: The resignation has been offered. I move you that we accept it with deep regret. Nobody appreciates what Dr. Chandler has done for this Society more than I do, and he is worthy of all the honor we can give him.

President Hunter: Gentlemen, you have heard Dr. English's motion. All in favor of accepting the resignation of Dr. Chandler signify by saying "aye;" contrary "no." It is so ordered.

You have heard the motion that we refer Dr. Chandler's name to the Committee on Honorary Membership. All in favor of that motion will signify by rising. The vote is unanimous.

Dr. Dickinson: Mr. Chairman, I dislike very much to have one of the Old Guard, who has been working with us for so many years simply pigeonholed in the Honorary Membership. I think, Mr. President, that this is one of those times when we should have proper resolutions drawn up, properly inscribed, and delivered to Dr. Chandler, so

that he may hang them in his library for the future.

Therefore, I would request that you appoint a committee of one or more who will be empowered to carry that idea out.

Dr. MacAlister: Mr. President, why not let the Committee on Honorary Membership do that?

President Hunter: It is immaterial which committee does it, just so long as it is done.

I feel we had better have a separate committee to do that so if it meets with your pleasure, all in favor of appointing this Special Committee to draft these complimentary resolutions on Dr. Chandler's faithful services will say "aye;" contrary minded? It is so ordered. I will appoint on that committee Dr. Dickinson, Dr. Schaufler and Dr. Costill.

(GENERAL SESSION.)

Dr. Chandler read the list of members of the Nominating Committee.

President Hunter: That concludes the naming of the Nominating Committee.

Dr. Pollak: Mr. President, I would like to bring to the attention of the State Society an evident error that is in the official program. On page nine, among the list of Presidents and Secretaries and Reporters of County Societies, in the Hudson delegation there is mentioned Dr. Charles Kelley as President. I desire to say that Dr. Lucius F. Donohue of Bayonne is the President of the Hudson County Medical Society and not Dr. Charles Kelley.

President Hunter: The correction will be made, Dr. Pollak.

Dr. Costill: Mr. President, we have with us this afternoon, I see, our old friend, Dr. Noble of Philadelphia. I move you, sir, that he be invited to sit with us as a corresponding member.

The motion was carried.

President Hunter: I am sure that the State Society would be glad to have a few words from Dr. Noble at this time.

Dr. Noble: Mr. President, if you don't mind, I will speak a little later.

President Hunter: Is there anything further; gentlemen?

Dr. Johnson: As Chairman of the Committee on Honorary Membership and in the absence of Dr. Sexsmith and Dr. Philip Marvel, in accordance with the expressed wish of the Society, I desire to present for Honorary Membership the name of its long-time efficient and hard-working Secre-

tary, Dr. William J. Chandler of South Orange.

President Hunter: You have heard the motion of Dr. Johnson as the Chairman of the Committee on Honorary Membership, presenting the name of Dr. Chandler for election to honorary membership of this Society. All in favor of this will give their assent by rising. The vote is unanimous.

Dr. Chandler: I desire to extend my thanks to the Society for this honor.

Dr. Johnson: I don't know whether it is in order or not, but I wanted to register my thanks also to the Council of the State Society; that is, the Judicial Council, as well as the Councilors of the State Society, and also to the Medical Defence Act in general for having defended me in a suit for damages to the amount of a quarter of a million dollars. I am very glad to say that after the case had proceeded for a long time and after I had borne the onus and discouragement of having been sued for so large an amount, which I didn't see how I would ever be able to pay in case they should win, and after having thought that I wasn't entitled to be sued at all, inasmuch as I was only the first operator and there was another fellow who operated a couple of times after I did, in the end justice was accorded us. This was an operation for mastoiditis, and the fellow testified that he made fourteen punctures in the cerebral cavity on the last operation and that the man died the next morning, and I felt I wasn't very guilty anyhow inasmuch as I only operated the first time, as they claimed inefficiency and not to the extent to which I should have gone.

I want to extend my thanks to the Judicial Council and to the committee for having defended me as far as they did. The case went to the judge and the judge dismissed the case.

President Hunter: Dr. Johnson's expression of gratitude to the Judicial Council is but another evidence of the very efficient work of this very efficient Council.

Under the Committee on Scientific Work, Dr. Mercer is down for the next proposition and his paper will be read by title as he is at home very ill, and the Scientific Committee has substituted in place of Dr. Mercer's address, a paper by Dr. Marcus W. Newcomb of Brown's Mills, "A Few Important Facts in the Diagnosis of Pulmonary Tuberculosis."

Dr. English: If you will permit me I should like to say I think there is an error about Dr. Mercer. He has prepared no

paper because at the last meeting of the Society the Third Vice-President was excused hereafter from presenting a paper.

President Hunter: Dr. Newcomb will now read his paper on "Pulmonary Tuberculosis."

Dr. Newcomb presented his paper.

This paper was discussed by Drs. Alex. Armstrong and Berth. S. Pollak.

(See elsewhere for this paper and discussion of it.)

President Hunter: If there is no further discussion we will proceed to the next paper, "Delatation of the Corvix Uteri, Podalic Version and Delevry of the Child Under Anesthesia," by Dr. James M. Hackett of Leonia.

This paper was discussed by Drs. W. J. Harman, Chas. P. Noble, Edward J. Ill, C. F. Underwood, G. E. Reading, A. J. Mitchell, J. M. Hackett and F. J. Keller.

(For Dr. Hackett's paper and the discussion of it see the October Journal.)

President Hunter: Gentlemen, I want to announce that we have with us, sitting alongside of Dr. Stewart, Dr. Egbert, who I belive is the Dean or Assistant Dean of the Post Graduate School of Pennsylvania. I am sure the New Jersey Medical Society would be glad to have a few words from Dr. Egbert.

Dr. Egbert: I came here on Dr. Stewart's invitation, simply to see if I could find out whether any of my old students were here. I was delighted to hear Dr. Noble's talk, but I have been out of practice so long that I hardly feel that I am competent to take part in discussions with practitioners. At the present time I am not Dean but Assistant Dean of the Post Graduate School. I have sort of an attachment to the Dean's Office in the Undergraduate School over there, because I have to look after the interests of some of our old medical graduates when their papers come back, having been transferred from one State to another. However, I want to say it is a pleasure to meet doctors, whether they are from California or not. A good many of my boys are out in California now and I hope they are not being harmed.

It has been a great pleasure to be associated with the school, because my father and father-in-law held positions in the old school, my father being a '55 man and my father-in-law a '56 man, going a good ways back. I had the pleasure on Saturday of meeting with a lot of the men who got back for our thirty-fifth reunion. The attachments are stronger every year, as I know every one of you appreciate.

I feel that we are in a transition stage; that is, that the boys who are coming along now are getting something that we did not get, and that many of us who have been in practice a good while always regret that we cannot get an insight into some of the research

and laboratory problems, as the boys get them in the Laboratory School.

I do feel, however, that there is a little danger at the present time in medical education, for training of specialists rather than training old-fashioned general practitioners, or, to put it in another way, good old-fashioned country doctors. I still have a very great admiration for the country doctor, a man like the gentleman who spoke here a moment ago and said he had been in country practice thirty-eight years. I feel certain he knows a good deal more than many of our boys who have just graduated and have had a good many specialties forced into them that makes them feel they know a lot about medicine. Of course a post graduate course takes out a lot of the egotism that a fellow has gotten in his under graduate course, but even then a great many of the boys go out thinking they are fit to go into general practice. As I said yesterday to somebody, I do not believe any man is quite fit to be a specialist until he has been in general practice for about five years; and that is why we have the Graduate School there at the University now. We are furnishing an opportunity for men who have been in general practice for a good while to get the things they need in order to make good specialists.

I think your President is trying to put one over on me as an old classmate but I do appreciate the opportunity of meeting you and the opportunity of coming in and listening to you.

President Hunter: Now, gentlemen, if there is no other business to come before the meeting at this time a motion to adjourn is in order.

On motion the meeting adjourned.

THURSDAY EVENING SESSION,

June 21, 1923.

The meeting convened at eight-fifteen o'clock, Dr. James Hunter, Jr., President, presiding.

The Vice-President, Dr. Eagleton, assumed the chair.

Chairman Eagleton: The first item on the program this evening is the President's address.

Dr. Hunter presented his address as President.

(For this address see July Journal.)

Dr. Hunter resumed the chair.

President Hunter: Now, with the permission of the Society I am going to transpose the program for this evening because we have the most important report of the evening, that of the Welfare Committee, to hear, so I am going to transpose the program for the present and put the fifth article in place of the fourth, and I call on Dr. Wells P. Eagleton, Chairman of the

Welfare Committee, for the Report of the Committee. Dr. Eagleton.

Dr. Eagleton presented his report.

President Hunter: Gentlemen, you have heard the Report of the Welfare Committee; what is your pleasure?

Dr. Pinneo: I move that the report be received and placed on file, and that the recommendations contained therein be approved.

The motion was seconded by Dr. Dickinson.

President Hunter: Gentlemen, the motion before the house is that the Report of the Welfare Committee be received and its recommendations be approved. All in favor will give their assent by saying "aye;" contrary? The "ayes" have it and it is so ruled.

(For the report of this committee and the discussion of it see the September Journal.)

The next item on the program tonight is a novel motion picture showing the entire process of digestion. This is the first time this subject has been shown on the motion picture screen.

The motion picture on the process of digestion was shown.

President Hunter: The next item is a paper on "Backache," by Dr. B. Franklin of Camden.

Dr. Buzby presented his communication, illustrated by slides.

This paper was discussed by Dr. Thomas B. Lee and Robert Soule.

(See the Journal for this paper and the discussion.)

President Hunter: I will again say, if there is any further discussion now is the time. If not, a motion to adjourn is in order.

On motion the meeting adjourned.

Meeting of House of Delegates,

FRIDAY MORNING SESSION,

June 22, 1923.

The meeting convened at nine-fifty o'clock, Dr. James Hunter, Jr., President, in the chair.

President Hunter: The meeting of the House of Delegates will come to order. The first item on the program is Unfinished Business. First I should imagine we ought to have a Secretary pro tem.

Dr. Dickinson: I nominate Dr. Pollak to act as Secretary pro tem. The nomination was seconded and carried.

President Hunter: Is there any unfinished business to come before the House of Dele-

gates? As there is none, we now come to New Business.

Dr. Pinneo: Mr. President, I was secretary of a meeting of the Essex County delegation and was instructed to present these two resolutions as coming from the Essex County delegation. The first is on the precedent, long recognized, of promoting the Vice-Presidents in due order, although it is a precedent and not written although it is not written in the Constitution or By-Laws and there might be embarrassment in not following the precedent. This resolution, therefore, is as follows:

"The delegates from the Essex County Society, in conference June 20, unanimously recommend to the House of Delegates the adoption of the following resolution:

"That we break the existing precedent whereby the vice-presidents are advanced in order, third, second, first, and instead, elect President and three Vice-Presidents on merit, regardless of preceding elections; provided, however, nothing in this action shall be taken to apply to officers now holding office under the former precedent, but only to elections in 1923 and hereafter.

"Therefore, nominations and elections at this convention, and henceforth, be understood to not imply, necessarily, further election or advancement in office, as from third vice-president to second, second to first, to president."

The idea being that it leaves the House of Delegates entirely free; it does not involve any necessary change in the present precedent or advance in office, and yet it removes any possible embarrassment.

"Secondly, the delegation also unanimously offers the following resolution:

"That the Medical Society of New Jersey is unalterably opposed to any annual registration of physicians and urges the State Board of Medical Examiners to find other means for prosecuting their work of detecting illegitimate practitioners, the only announced reason why this Board stands for this method, unpopular, unjust and inadequate for the purpose."

President Hunter: Dr. Pinneo, we will take those separately; we will take the first one first. Gentlemen, you have heard the resolution as offered by Essex; what is your pleasure?

Dr. Dickinson: I move that it be accepted and filed.

DISCUSSION.

Dr. Schaffler: Mr. Chairman, as one on whom it can never have any bearing, I should like to say just a word. The reason for this

seems to be that the House of Delegates shall have free choice of the men to be nominated and elected. As a matter of fact, the House of Delegates appoints the Nominating Committee, and the members of the Nominating Committee must voice the sentiment of their own county societies, and the Nominating Committee is perfectly free to nominate whomsoever it wills, whether it nominate the First, Second or Third Vice-President in rotation or an entirely new set. I do not think that the Essex County delegation wish to make nominations from the floor; that would not be in accordance with the Constitution. Therefore I do not see how that will help matters from their standpoint, as long as they have a Nominating Committee and their member instructed on the Nominating Committee. It does not seem to me that it is necessary to throw the precedent overboard in order to get what they want.

President Hunter: Are there any further discussion?

Dr. I. T. Topkins: Mr. President, I represent the Hunterdon County Medical Society and I was on the Nominating Committee when this question came up last evening, and all the members, including Dr. Spröul and Dr. Ill, thought that it was up to the House of Delegates. So that is the answer to Dr. Schaffler. The House of Delegates, according to Dr. Schaffler, have no business to nominate, but according to these people, the House of Delegates have the right; so we don't know where we stand. As far as Hunterdon County Medical Society is concerned, we always thought that the precedent should be broken up; that any new man can be nominated as Vice-President, and so on.

Dr. W. B. Johnson: Mr. Chairman, there seems to me to be a sort of a general misunderstanding in this matter. This resolution, in the first place, is so worded that there is not any legality to it. It says "for 1923" this action shall be taken. The regular machinery of the Society has operated up to this time in relation to this matter and the nominees have been selected by the Nominating Committee, which is ready to report. This can only be accomplished, in my judgment, by a change in the Constitution and By-Laws in regular form. It is all very well for us to say there isn't any compulsion to do this in this way, in the Constitution and By-Laws, but there is! The Nominating Committee is appointed in accordance with the Constitution and By-Laws. The Nominating Committee has to proceed in legal form to do certain things, and those certain things are to nominate people for office. Now, in order to change this method, this resolution is absolutely inefficient; it would not cover in any way the ground that it is necessary to cover to meet this situation. I am not arguing against the situation of whether or not we shall have a president and four vice-presidents; I am saying that anybody on the floor of this house, in a meeting of the House of Delegates, at any time can nominate a man from the floor for any position, in accordance with the Constitution, and if he has enough votes we can elect him. There isn't anything preventing a man from rising on the floor and nominating him, but there is a specific way

in which the officers shall be nominated and that is through the means of the Nominating Committee, which Committee is definitely appointed by the Constitution and By-Laws for a specific purpose. And you can't break up the Nominating Committee; you can't rise on the floor alone and make nominations—you must fix your Constitution and By-Laws to meet the situation. The only argument in favor of it, that I have ever heard is that out of two thousand members it will give more people a chance to be vice-president of the Society. It won't give any more people the chance to be President of the Society, but it will give more people the chance to be vice-president. Well, if the Vice-President is elected in that way the vice-presidency will be an empty honor. It is not an empty honor as it stands now. When a man is elected Third Vice-President he passes through the regular stages in due form, and the delivery may be pretty slow, but finally he lands. Gentlemen, I always said I don't believe in reform, I believe in the machine.

Dr. Linn Emerson: Mr. President, it seems to me that this motion is out of order for the House of Delegates to take action upon. It is not a motion to change our By-Laws, it is not a motion to change our method of election. There has grown up a precedent in this Society of nominating a third vice-president and promoting him; but there is nothing in our laws that makes that necessary, and as far as that is concerned, if the Society or the House of Delegates or the Nominating Committee choose to do so, they can do it now without this motion. This motion, as I see it, is simply a desire on the part of a certain number of the Society to change the method; that is, now if our Nominating Committee sees fit to nominate for President any man who has not been a vice-president of this Society, they are at perfect liberty to do it; there is nothing in the By-Laws that prevents it. Consequently, if the man and the members who wish that change will present the resolution at a meeting of the Society, not at a meeting of the House of Delegates, if it is adopted, it would convey to our officers and to our Nominating Committee the idea that our Society as a whole are now in favor of nominating new men, so to speak, and not promoting our former vice-presidents. If that is the sentiment of the entire Society, that we wish to do that, well and good, but it does not seem to me that this resolution has a place in the House of Delegates, because if our State Society wishes to change the method and not promote our vice-presidents to the presidency, they have it within their power to do it without any motion at all. We can do it. We are not bound, except by an unwritten law. We have been doing it in the past. Consequently, if these men want that changed, they should go out and do some missionary work and convince a majority of the members of our State Society that we should change that method. Then, in our opening meeting, we can pass a resolution and the large majority of our Society can express such wish and our House of Delegates and Nominating Committee can be so bound; but it seems to me that the motion is out of place in the House of Delegates.

Dr. Dickinson: Some dozen or more years ago I was nominated Third Vice-President of the State Sanitary Association, which runs very much on the same lines as this Society. There was a person, I think, who was Second Vice-President, who, in the interim had done some little things to estrange himself. He was dropped and I was run right up to the First Vice-Presidency. Now, if there is something like that which brought up these resolutions presented by Dr. Pinneo, and if they feel that there is somebody in line that they want to "do," let them go ahead without disturbing our usual method. That is the way to handle it. The way is open without asking any alteration whatsoever in our By-Laws or Constitution.

Dr. T. W. Harvey: Mr. President, I think we have gotten a little tangled up, as we always do in this matter. The Essex County people had an idea that they would like to spread these honors around. This House of Delegates is the only body that can vote anyway, and this is the place to discuss it; and if we wish to issue instructions to the Nominating Committee that they should not be bound by the precedent, we are perfectly competent to do it. That, I believe, covers the situation.

Dr. Emerson: I feel that we, as a House of Delegates, ought not to be the ones to instruct that Nominating Committee. I feel that that change should not be made unless the State Society as a whole wants it done. As Dr. Harvey says, we are the ones who do it; but if there is a sentiment that that should be changed, I feel it should come from the house as a whole.

Dr. MacAlister: I move that it be laid on the table.

Dr. Eagleton: Evidently Dr. Emerson does not understand the thing. What Essex County is aiming at is this: There are two thousand members of this Society. There is but one man elected every year, and in the lifetime of the Society, in a decade there can be but twenty men honored by being the President. That means only one in a hundred has the opportunity. Essex County said that they thought it was an advisable thing that the system of the American Medical Society should be adopted; that there are many men who could be elected vice-president, provided we elected a president and three vice-presidents every year, four men a year thereby being honored.

Dr. Johnson: But it is no honor to be a vice-president if you do not go any further.

Dr. Eagleton: I think it is a great honor to have been a vice-president. When Dr. Charles Kipp was elected a vice-president of the American Medical Association, he was very, very proud of it, and he hadn't any idea of being in the House of Delegates for years and years. He hadn't any idea because he was elected vice-president, that he was going to be made president. A number in Essex County thought the same thing should happen. It is a matter of being able to honor more than one man a year in a large society of two thousand. It is a custom that we have had for years. If you don't want it, it is all right.

Dr. Lee: Mr. President, a number of years ago I had the pleasure of bringing this matter

up in the House of Delegates' meeting, and of course, coming from an unimportant county like Camden, we did not get much hearing. I felt just as Dr. Eagleton does, that it is a great honor to be vice-president of this society. I also feel that just as there are differences in men everywhere and under all conditions, some men perhaps are worthy of the honor of being president, whereas others perhaps are not quite so worthy, in comparison with their fellows, of that honor. These men we can give the lesser honor of being vice-president. I think that the duties of the president, which are rather onerous during these two or three days, might be divided up a little bit so that these vice-presidents might have something to do. It is true, as one of the speakers has said, that this is simply precedent; there is no law of the society whereby we have to advance a third or second of first vice-president to the president's chair, but just the same, precedent is sometimes as strong as law itself, and as things go at the present time, if a man is not advanced in the manner in which it has hereto been done, it might be regarded as rather a slight on him. As Dr. Eagleton says, very few men can have this honor, and I think it is very foolish to honor one man four times by making him first, second, third vice-president and then president. I think we might distribute these honors and create a greater interest in the elections. I am very much in favor of destroying this precedent.

Dr. Pinneo: Mr. President, Dr. Eagleton referred to Dr. Kipp. I was very much grieved when I found that Dr. Kipp was not nominated as president of the American Medical Association. I found that the president was picked on his merits, regardless of whether he had been formally or not. Dr. Eagleton has stated that Dr. Kipp was very proud of his vice-presidency, and no one will deny that, but isn't the A. M. A. a better administered organization for being able to pick four men and honor them all at once and have every one of them satisfied and the entire society better contented? Why not give your vice-president something to do that will be an honor? That means simply changing your constitution and by-laws. This resolution does not mean any change; it is only the expression of opinion to the House of Delegates. It is better to do that than to break this precedent and call forth some embarrassment and some hard feeling.

Dr. Johnson: A motion has been made to lay this matter upon the table. That question should be put, but even if this motion is passed in due form, in accordance with the constitution and by-laws, the nominations have been prepared and made in a meeting at the proper time, and they cannot be changed for 1923. Therefore, the resolution cannot be passed and operate.

President Hunter: Gentlemen, you heard the motion to table the resolution. All in favor signify by saying "aye"; contrary? We will have a standing vote. All in favor of the resolution will signify their assent by rising. Twelve voted in the affirmative. All those opposed to tabeling this resolution,

rise. Thirty-five voted in the negative. The motion to table is lost.

President Hunter: Now gentlemen, you have heard the resolution as introduced by Essex. Are you ready to vote on that proposition? This resolution applies to the 1923 election, of which Dr. Johnson has said they have completed their nominations.

Dr. Harvey: I think "1923" should be changed to "1924."

President Hunter: Do you offer that as an amendment?

Dr. Harvey: Yes, I will offer that as an amendment.

Dr. Pollak: I will second that amendment. I think it is only fair that the gentlemen who accepted nominations yesterday afternoon under the established custom heretofore prevailing were not aware of this resolution and hence it is not fair and ought not to apply to any of the gentlemen who were nominated by the Nominating Committee yesterday afternoon. Therefore I second the amendment, so that that might apply in 1924 and not in 1923.

President Hunter: All in favor of the amendment give their assent by saying "aye," contrary? The "ayes" have it, so it is now changed to 1924.

President Hunter: What is your pleasure, gentlemen, in reference to the motion as amended? Are you ready for the question?

All in favor of adoption of this resolution, as amended, will signify their assent by saying "aye," contrary? The "ayes" have it.

We will now have the second resolution read.

Dr. Weeks: "The delegates also unanimously offer the following resolution: That the Medical Society of New Jersey is unalterably opposed to any annual registration of physicians and urges the State Board of Medical Examiners to find other means of prosecuting their work of detecting illegitimate practitioners, the only announced reason why this Board stands for this method, unpopular, unjust, and inadequate for the purpose."

It was voted, upon motion regularly made and seconded, that the resolution be adopted.

President Hunter: Is there any other item of business to come up at this time under the head of New Business? Is any member of the Business Committee present now? If not, a motion to adjourn the House of Delegates is in order.

Dr. Weeks: I move that we adjourn. The motion was seconded and carried, and the House of Delegates adjourned.

General Session
FRIDAY MORNING
June 22, 1923.

The General Session convened at ten twenty-five o'clock, Dr. James Hunter, Jr., President, presiding.

President Hunter: Now, gentlemen, we will open the general session, and the first item on the program is the "Oration in Medicine," by Dr. Berthold S. Pollak!

Dr. Pollak presented his oration.

President Hunter: Ladies and gentlemen, I am sure you will agree with me, that you have heard one of the treats, if not the treat of the 1923 session of the Medical Society of New Jersey. This oration, teeming with lofty thoughts and ideals, teeming with the humanity and the altruistic principles which have governed us in the past and should govern us at this moment, should be helpful to every listener in this room today.

Dr. Dickinson: I move you, Mr. president, that in token of our appreciation of this lofty paper of Dr. Pollak's, that we give him a rising vote of thanks.

The motion was carried, the audience arising and extending applause to Dr. Pollak.

(For this oration see the September Journal.)

President Hunter: Now we come to the next item on our order of business, "The Treatment of Malignant Diseases by Means of the New Higher Voltage Shorter Wave Length Roentgen Rays—Radium and Electrothermic Coagulation," by Dr. J. Thompson Stevens of Montclair.

Dr. Stevenson presented his communication, illustrated by slides.

President Hunter: I am sure you have enjoyed this paper. I will ask Dr. Wyatt, of Newark, to open the discussion on this paper.

Dr. Wyatt presented his written discussion.

President Hunter: This paper is open to discussion. We have a number of men who are interested in xray work in the audience, I will call on Dr. Roberts to start the ball.

This paper was discussed by Drs. J. H. Wyatt, H. H. Roberts, F. J. Keller, Jacob Roemer and J. T. Stevens.

For Dr. Stevens' paper and the discussion of it, see the November Journal.

President Hunter: Is Dr. Ewing of Newark, present? The next item is "The Prevention and Relief of Heart Disease," by Dr. Harvey M. Ewing of Newark.

Dr. Ewing presented his communication.

Dr. Ewing: I have a few slides illustrat-

ing the work and showing some of the exercise work as carried out at the Mineola Home for Cardiac and also in the Burke Foundation at White Plains, just a very few, to give you some idea of what these cardiac children and adults do. Slides were shown.

President Hunter: I am going to impose on the good nature of Dr. Stewart and ask him to open the discussion in the place of Dr. Teeter, who is unavoidably absent.

This paper was discussed by Drs. W. B. Stewart, C. W. Crankshaw and H. M. Ewing.

(For Dr. Ewing's paper and discussion thereon see original article in later Journal)

President Hunter: The next number on the program is "Gastric and Duodenal Ulcer. Medical Treatment and Surgical Indications," by Dr. Fletcher Freeman Carman of Newark.

Dr. Carman presented his communication followed by slides.

This paper was discussed by Drs. Edward J. Ill, C. A. Hofer, J. B. Morrison, C. W. Crankshaw and F. F. Carman.

(For Dr. Carman's paper and the discussion thereon see original article in a later Journal.)

Upon motion, the meeting adjourned.

House of Delegates

FRIDAY AFTERNOON

June 22, 1923

The meeting convened at two forty-five o'clock, Dr. James Hunter, Jr., President in the chair.

President Hunter: The meeting will come to order. Just as a preliminary prior to going into formal program of the committee, there are two propositions that I want to bring before you at this time. I am going to ask Dr. Costill to say a word to you in reference to Dr. Schauflier's proposed visit to England.

Dr. Costill: Mr. President, Dr. Schauflier has just informed me that he expects to attend the meeting of the British Medical Association, to be held in Plymouth, Great Britain, this summer. I think it would be no more than courteous and proper that this society should send Dr. Schauflier, or give him credentials as coming from this society, as a representative of the New Jersey State Medical Society, and I make that as a motion.

Dr. Johnson: I second that motion.

Dr. English: I would second it with all my heart, and I want the thought conveyed

to them that we are the mother of medical societies in America.

The question was put by the president and the motion was carried.

President Hunter: There is another proposition in connection with the Chairman of our Welfare Committee. One of the papers has come out with an absolutely false statement in reference to an attack that has been made upon the State Commissioner of Charities, Mr. Lewis, and I want to give Dr. Eagleton the privilege of the floor for a few minutes. Dr. Eagleton!

Dr. Eagleton: Mr. President, I would ask, inasmuch as we should wash our dirty linen among ourselves, that this meeting be confined entirely to the delegates of the State of New Jersey and that all visitors be requested to retire. I also wish to state that we have had too much newspaper publicity, which is not accurate, and what I have to say is not to be given to the press. We will give our own stuff to the press in our own time, and it will be accurate.

In the souvenir program you will find a statement entitled, "The Aims and Objects of the Welfare Committee," by Wells P. Eagleton, M. D. I did not read that until this morning, although I knew there was something there.

A reporter from the Associated Press came here yesterday. I might state that this article is not dated, it is a reprint of the report of some years ago, which appeared in the Journal. It is simply an error on the part of the Program Committee. I have talked to Dr. Olmstead, and I find it is a perfectly honest mistake, that they wanted something to fill up the program and they gave this, and the printer has printed it without putting any date on it at all. It is a perfectly unintentional mistake.

A reporter comes here; reads this, and he gives out this statement, which has been broadcasted all over the United States; it was carried this morning in the New York Times like this: "Burdette Lewis Target of Hot Attack Launched at State Medical Meeting." This same thing has been given to the entire press. This is a serious matter. What is it going to do? The Governor is going to read this. We just had a conference with the Governor. We didn't say anything like that. He will say, "What kind of fellows are those, to come down and talk one way and go out in a meeting and assail one of the departments?" It is bad business. The reporter who is responsible for this is to meet me at five o'clock. At that time he has to withdraw it. How-

ever, I wanted every member to know how it happened. It was a perfectly innocent mistake made by the Program Committee. They did not read it and they did not submit it to me. They thought it was good stuff, and it was good stuff two years ago; at that time it was all true, but it is not true now.

The Program Committee has done a wonderful piece of work for this society, and this occurrence is unfortunate, but it shows how careful we have to be in handling publicity. Newspaper reporters want to get every scandal. On the other hand, after the meeting I gave what matter I thought was going to be a benefit to us to a reporter, and you will find that in other papers, and that is good stuff. They say that we petitioned the Governor to appoint five physicians to smooth over the scandal of the Workingmen's Compensation Law; even after I gave them the stuff, the fellow got it wrong.

Dr. English: They like to make a big story for us.

Dr. Eagleton: That is the first matter.

The second matter is this: I have had considerable correspondence with Senator Whitney. We have done a slight injustice to Senator Whitney and he is entitled to a correction, as far as it goes. He wrote a long letter, which I do not think is worth while reading, saying that he had been misrepresented by Mr. Gunn, to the Morris County Society. This is his first letter. Dr. Eagleton read the letter from Senator Whitney. I answered his letter this way: Dr. Eagleton read his response to Senator Whitney.

Dr. Eagleton: He came back at me again and said I was dodging the issue, and here is his letter: Dr. Eagleton read this letter from Senator Whitney.

We took the only course to straighten the matter out, because there were a number of bills this way and that, and the only thing to do was to go back to the different bills and see from the records how they voted on all those bills; so I have drawn up this letter to Senator Whitney: Dr. Eagleton read the letter addressed to Senator Whitney. That straightens the matter out.

Senator Fooder made a statement last night that would tend to give a very wrong impression. I am sorry Senator Fooder is not here. I did not answer many of his statements last night, and I do not think they need to be answered, excepting to put on record the cause of the whole trouble. I did not at that time have the dope with me

and I sent Mr. Gunn back to get the official record of what happened, and this is what happened: There was introduced by a body of chiropractors a bill which was practically a blanket bill (this was in 1923) that would license every one who was in practice at that time of the passage of our Senate 149, the Limit of Practice Act. They claimed a great injustice had been done them; that they should have been licensed by the old board, but examination showed that the old Chiropractic Board had refused to license these men. They came to me, and I said, "But how can we recognize and allow you to be licensed when your Chiropractic Board refused?" I said, "We would be in a nice position, wouldn't we, after fighting for a bill and fighting for educational standards and supporting it, and then passing another bill that refused license by board?" At any rate, it was introduced and it was a very easy thing to defeat it. You were immediately circularized, saying to oppose this bill. It went to the Assembly and was defeated. It went back, and a few days later it appeared again in the Assembly with this statement: That this bill was satisfactory to the doctors; and when we denied it, they said it had been prepared in the rooms of the State Board of Medical Examiners.

There is some confusion about this, but that was the statement, and on that statement, it went through the Assembly. That bill did not contain any provisions whatever for an examination, but required a two year course of six months each, a certificate of a diploma or an affidavit of the college to be filed with the State Board of Medical Examiners. In other words, that passed the Assembly by the statement that the State Board of Medical Examiners were behind it. Now I may be doing the State Board of Medical Examiners an injustice, but those were statements that were made and we were furious. At that time I was in the hospital with an infected hand, and I thought, "Well, this is a nice thing: We go and fight for a principle and then the Board agrees to a measure and gives it more or less the endorsement of the profession by saying the doctors are satisfied;" and when we said we were not satisfied, they replied that it was prepared in the rooms of the State Board of Medical Examiners and it did not require any examination whatever. This bill passed the Assembly on that statement. It came over quickly to the Senate; it went to the Senate and was locked in Senator Fooder's desk and remained there. I think, about one

month. At this point I want to say I exonerate the members of the Board; they did not know what they were doing. I am sure.

On the last day of the session, Mr. Gunn was there and we thought the thing was dead. Mr. Gunn came to my room in the hospital and said, "The chiropractors say that they will submit to an examination." I said, "That's what we want. We are not trying to oppose these fellows, but we want to show that we are honestly fighting for educational standards; we are not having a campaign of no compromise. Go down and get the thing fixed up." Mr. Gunn went down. About half past two or three o'clock in the afternoon I got a telegram: "They are willing to submit to examinations"—giving some other provisions. I telegraphed back, "Accept that, if Costill, who is on the ground, is willing; if he approves." They telephoned Dr. Costill: he is a busy man, like the rest of us, and he did not go. That is all over, but remember a month has elapsed. Then at last when they did appear, the unpleasant incident occurred between Dr. Costill and Dr. Fooder, which was entirely a personal matter, and the bill went through. However, what I want to straighten out is this: That your Welfare Committee by its efforts prevented legislation and wrote into the bill educational requirements and required them to pass an examination.

I make this statement, not for publication, but simply to keep the records straight, as we see it. I received a telephone call from Mr. Gunn that Bill 225, the original amendment, did not contain any requirements for an examination. That is why I make this statement.

President Hunter: Dr. Reddan!

Dr. M. W. Reddan: I want to assume full responsibility for those statements appearing, Dr. Eagleton. I did not see the statements until they were in type. On re-reading the proof, I consulted with Dr. Olmstead and I said, "We had better be sure about this." "Well," he said, "whatever you say will go." I said, "It has appeared in our Journal as public property." What he said then was all true, and I guess we had better let it go, but at the same time I had inserted on page five, "The Officers of the Society and the Committee on Program and Arrangements are in no way responsible for any statement made or opinion expressed in this Convention Book other than those made in the Announcements and Daily Program." I did not want

to commit the Society to those statements. I want to assume full responsibility for what I believe is my mistake.

Dr. MacAlister: I want to deny the statement that we did not have an examination requirement put in that bill. As Dr. Fooder stated here last night, he came up to my office after they had been telephoned, to put that requirement in there of three six-months' course and a year's residence in the state, and it was prepared in my office by Mr. Lanagan, one of the staff of Attorney General McCran. This is a fact.

Dr. Eagleton: I am perfectly willing to say that that may be so, but Assembly 225 came about and this whole awful mixed up mess occurred because we did not get together. However, Assembly 225 did go to the Assembly without that educational requirement and with the statement that it was satisfactory to the doctors because it had been prepared in the rooms of the State Board of Medical Examiners, and I am perfectly willing to believe it is so, but as I say, it may be all a bull.

President Hunter: Dr. Eagleton, before you sit down will you just kindly state to the Society what you want us to do to straighten out this matter? Do you want any official action taken by this body?

Dr. Eagleton: None at all. We merely want the records straight among ourselves. I don't want the Welfare Committee to be put in the position that they were trying to fight any board. They were merely trying, from the beginning to the end, to uphold educational standards. The committee does not oppose any board but wants to co-operate. When we fought Dr. Fooder, we were fighting because we wanted educational requirements in the bill.

President Hunter: Gentlemen, you have heard the statement. We have a big afternoon ahead of us. I think Dr. Eagleton has wiped his slate clean.

Now we will proceed to the business of the afternoon. The report of the Nominating Committee is in order. Dr. Johnson!

Report of the Nominating Committee.

The meeting of the Nominating Committee was held at 5.30 P. M., Thursday, 21st inst. Dr. E. J. Ill was elected Chairman and Dr. Walter B. Johnson, Secretary.

The roll call follows: Atlantic County, W. J. Carrington; Bergen County, Joseph Payne; Burlington County, M. W. Newcomb; Camden County, A. Haynes Lippincot; Cape May County, ; Cumberland County, H. G. Miller; Essex County, E. W. Murray; Gloucester County, S. F. Ashcraft; Hudson County, John Nevins; Hunterdon County, I. Topkins; Mercer County, A. J.

McGuire; Middlesex County, A. L. Ellis; Monmouth County, Morris County, ; Ocean County, Passaic County, H. H.

Lucas; Salem County, R. M. A. Davis; Somerset County, D. F. Weeks; Sussex County, ; Union County, Stephen T. Quinn; Warren County, L. C. Osmun;

Five Delegates from Board of Trustees—O. H. Sproul, D. C. English, E. J. Ill, H. B. Costill, W. B. Johnson.

The following Officers and Committees were nominated: President, Wells P. Eagleton; First Vice-President, Alexander MacAlister; Second Vice-President, Archibald Mercer; Third Vice-President, Lucius F. Donohue; Corresponding Secretary, W. J. Carrington; Treasurer, Elias J. Marsh; Trustee Five Years, J. Harris Underwood; Councillors, First District, Mefford Runyon; Second District, Henry Spruce ; Third District, Edward S. Hawke; Fourth District, Thomas B. Lee; Fifth District, Walt P. Conway.

Committee on Publication—Edward J. Ill, three years.

Committee on Scientific Work—Franklin J. Keller, term expires 1925; W. E. Darnell, term expires 1926.

Committee on Hygiene and Sanitation—Gordon K. Dickinson, term expires 1926; Walt P. Conway, term expires 1926.

The nomination of Delegates and Alternates to the American Medical Association was left to be filled by the Board of Trustees.

Committee on Program and Arrangements—William Schaufler, term expires 1926.

Meeting place next year, Atlantic City, selection of Hotel and Date left to Board of Trustees.

Resolved that the thanks of the Nominating Committee be extended to Dr. William Carrington and the Committee on Arrangements for their excellent service.

Delegate to Pennsylvania State Meeting—W. Blair Stewart.

Resolved that the Secretary of the Society be authorized to appoint Delegates to other State Societies.

Respectfully submitted,

WALTER B. JOHNSON, Secy.
EDWARD J. ILL, Chairman.

President Hunter: Gentlemen, you have heard the report of the Nominating Committee; what is your pleasure?

Dr. Newman: I move that the report of the Nominating Committee be received, and that we proceed to the election. The motion was carried.

President Hunter: We will now proceed to the election. A motion is in order, if there are no other candidates nominated, for the Secretary to cast the ballot.

No other nominations were made.

Dr. Mitchell: I move that the Secretary cast the ballot for the names that have been submitted by the Nominating Committee.

The motion was carried.

President Hunter: I will appoint Dr. English and Dr. Reading as tellers, and the Secretary will cast the ballot.

The ballots were cast by Dr. Chandler and Dr. Reading reported as follows: Mr. President, your tellers find the following unanimously elected as the officers of this Society: President, Wells P. Eagleton, First Vice-President, Alexander MacAlister Second Vice-President, Archibald Mercer; Third Vice-President, Lucius F. Donohue; Corresponding Secretary, W. J. Carrington; Recording Secretary, John B. Morrison; Treasurer, Elias J. Marsh; Trustee Five Year, J. Harris Underwood; Councilor, First District: (Dr. Reading read the entire list.)

President Hunter: I declare these officers elected. I would like to ask Dr. Donohue to come to the platform for a moment. Dr. Donohue stepped up to the platform.

President Hunter: Now, gentlemen, I want to present to you the President-elect, Dr. Eagleton, and the elected Third Vice-President, Dr. Donohue, and I want you to greet them with a rising vote of congratulation. All arose and applauded.

Dr. Donohue: I would just like to take this opportunity to thank the delegates for electing me as the Third Vice-President of this honorable Society. I also would like to state that I will do my very best to uphold the traditions and maintain the ethics of this Society and be ready at all times to help in any way possible to have it continue as one of the greatest societies in this country.

President Hunter: Now I want to ask Dr. Reddan and Dr. Olmstead to come to the platform for a moment. Both gentlemen stepped up to the platform.

President Hunter: Gentlemen, I think you will all appreciate the fact that this has been a successful meeting, and I want to present to you the men who have contributed largely to the success of this meeting—Dr. Reddan, the Chairman of the Committee on Arrangements, and the working Secretary, Dr. Olmstead. I want Dr. Reddan to say a few words to you to forecast next year's meeting, and I want a word from Dr. Olmstead. Dr. Reddan!

Dr. Reddan: "Build thee more stately mansions, O my soul!" There are several things we fell down on this year. We learn by our mistakes. Dr. Eagleton has called our attention to one of them, a very glaring one, and perfectly honest. His remarks seemed so full of meat and so full

of truth and we wanted expressions from men like him, therefore that slipped in. Next year we hope to establish a little daily bulletin patterned on that of the American Medical Association, giving the daily arrivals, their home addresses and their Atlantic City addresses. You notice I say Atlantic City; that is understood. My attention was called today by Dr. Reilly, of Elizabeth, to the fact that he wanted to hear a paper read that was on the program for tomorrow and it was slipped in this morning, so he missed it. We will try to avoid an occurrence of that kind in the future. We welcome criticism; we welcome advice; we will take it as constructive criticism. If there are any gentlemen who at any time have anything to tell us, to improve the work of the Program Committee, to make the program more enjoyable and profitable to the members and guests, we would appreciate it if they would drop us a note at any time.

President Hunter: Now we will have just a word from Dr. Olmstead.

Dr. Olmstead: Mr. President it is a great deal easier to work than it is to speak sometimes, especially if one has to follow an Irishman who has the ability to use such flowery language as you have just listened to. I guess I was primarily responsible for that error which occurred. I dug it out of the old file of the Journal as something worth while, indicating the aims and objects of the Welfare Committee, but I did not know there was so much criticism of State officials contained therein. Dr. Reddan wants to assume full responsibility for this mistake, but I am perfectly willing to assume my share of that responsibility. I can only say that it has been a great pleasure to do something and really get some tangible results, and I feel that we have actually gotten a very definite result. The exhibitors tell us that our meeting compares favorably with many of the national meetings they have attended, and I think that is one of the biggest compliments we can expect to get. Next year we can only promise you a smaller program and a larger meeting.

President Hunter: Now, gentlemen, let us give them a rising vote of thanks for their services this year.

President Hunter: Now I would like to introduce the new Corresponding Secretary, Dr. W. J. Carrington. Is he in the room? He is on the job, so we will excuse him this time.

Is Dr. J. B. Morrison in the room? I feel

t is presumptuous upon my part to attempt to introduce Dr. Morrison to this body, but I just do it as a pleasant formality, and I am sure we would be glad to have a few words from him at this time.

Dr. Morrison: Mr. President and fellow members of the House of Delegates: It is not an easy job which you have conferred upon me, and I don't know whether to thank you for it or not. However, I will have to ask your patient indulgence and tolerance until I have become acquainted with the details of the office, and I promise to do everything within my power to carry on this work.

President Hunter: Let us give a rising vote to Dr. Morrison. A rising vote was extended to Dr. Morrison.

President Hunter: Is there any unfinished business to come before the house at this time?

Dr. Pinneo: I move a rising vote of thanks be given to Dr. Hunter for the splendid manner in which he has presided over our meetings.

Dr. Eagleton: There is a motion that we extend a rising vote of thanks to Dr. Hunter for the manner in which he has conducted the meetings and contributed so much thereby to the success of them. All in favor signify by rising.

The entire membership arose and applauded.

President Hunter: Is there any other unfinished business to come before the house at this time? If not, we will call for the Report of the Business Committee, Dr. Weeks.

Dr. Weeks: There has been no business referred to the committee.

Dr. Hunter: Miscellaneous Business is next. Is there anything to come before the house under this heading. Dr. Dickinson, I believe, has a distinguished guest whom he would like to introduce to the Medical Society at this moment.

Dr. Dickinson: Dr. Tom Williams, of Washington, D. C., a noted psychiatrist, the writer of books and the analyzer of the mind! You have undoubtedly read some of his articles. He and Pottenger, to my mind, are the most acute writers we have in the States. We are all longing for somebody to take the place of Osler. No one will know who will take his place for some generations yet, but I like the writings of Dr. Tom Williams and I will introduce you to him.

All arose and greeted Dr. Williams with applause.

Dr. Tom Williams: Mr. President, Dr. Dickinson and Gentlemen: I am quite unprepared for this. I don't profess to be a writer. I am a clinician, a neurologist. But I am very glad that Dr. Dickinson did not call me one thing. I do not like to be called and am called quite often, and that is — he called me an analyzer of the mind, to which I do not object; but if he turns it around and says psychoanalyst. I do object. But he was very wise in what he said.

It is a great pleasure to be at this meeting. It was a special pleasure to have heard this morning "The Oration on Medicine" and the ideas expressed therein. I felt very sympathetic to those ideas. I think that we, as a profession, must place those ideas more strongly, more coherently, and more co-operatively before the general public. I have felt that for many years. It is a great pleasure to hear this great State Association voicing those ideas so eloquently, and the confirmation of that eloquent presentation by the enthusiasm with which the address was received.

President Hunter: Is there any other business under the head of Miscellaneous Business. If not, we will proceed with our scientific program.

General Session.

President Hunter: The next three items are practically along the same line: "Reform Diet as a Therapeutic Measure in Ophthalmic Practice," by Dr. George Huston Bell; "Musings of a Stomach," by Dr. Dickinson; and "Gastro-Intestinal Cases as Studied During Twenty-nine Years' Active Practice of Medicine in Atlantic City," by W. Blair Stewart. I believe it would be well to have all three of these papers read in toto, before we have the discussion and then conclude with one discussion which will cover the three papers. What is the sense of the Society?

If it is your wish that it be so handled, we will call on Dr. George Huston Bell, of New York City, for his paper on "Reform Diet as a Therapeutic Measure in Ophthalmic Practice."

Dr. Bell presented his communication.

Dr. English: I offer a motion that Dr. Tom Williams be invited to sit as a corresponding member at the sessions of our annual meeting and take part in the discussions of papers.

The motion was carried.

President Hunter: The next paper is entitled, "Musings of a Stomach," by Dr. Gordon K. Dickinson.

Dr. Dickinson: I want to blame George Sommer for this paper. If it hadn't been for him, I would not have brought before you this little bit of scientific levity. Dr. Dickinson presented his communication.

President Hunter: Now we will hear from Dr. W. Blair Stewart, of Atlantic City, on "Gastro-Intestinal Cases as Studied During Twenty-nine Years' Active Practice of Medicine in Atlantic City." Dr. Stewart presented his communication.

President Hunter: Now we will have the discussion on these papers, and we will have them discussed by four men: Dr. Robert Rose of New York, Dr. Philip Norman of New York, Dr. W. D. Olmstead, and Dr. H. B. Costill. I will call on Dr. Robert Rose of New York first.

Dr. Rose presented his written discussion.

For these papers and the discussions thereon see original articles in subsequent issues of the Journal.

Upon motion the meeting adjourned.

General Session.

SATURDAY MORNING.

June 23, 1923.

The meeting convened at nine forty-five o'clock, Dr. James Hunter, Jr., President, in the chair. Dr. Morrison was requested by the President to act as Secretary pro tem.

President Hunter: The meeting will come to order, please.

The first item on the program is entitled, "Operative Reduction of Fracture of the Femur," by Dr. Robert E. Soule, of Newark.

Dr. Soule presented his communications, illustrated by slides.

This paper was discussed by Drs. J. P. Reilly, C. L. Andrews, G. H. Sexsmith, Edgar Holden, F. W. Pinneo, W. C. Westcott and R. E. Soule.

This paper and the discussion thereon will appear in a subsequent issue of the Journal.

President Hunter: Now, gentlemen, I think a vote of thanks is due Dr. Soule for his splendid paper, and I should be pleased to entertain such a motion.

It was voted, upon motion, that a vote of thanks be extended to Dr. Soule for his splendid paper.

President Hunter: For the benefit of the financial end of the Medical Society at this time I am going to sandwich in, for four or five minutes, a short talk by Dr. Christopher Beling, the Chairman of the

Committee on Medical Defence and Indemnity Insurance. I think it is a very important proposition and therefore I take the privilege of asking Dr. Beling to speak to us for a short time.

This report was discussed by Drs. W. P. Eagleton, T. W. Harvey and J. B. Morrison.

For Dr. Beling's report see the September issue of our Journal.

Dr. W. B. Johnson: I move that the report be received and that the recommendations be adopted.

The motion was adopted.

President Hunter: The next item on the program is "Concerning the Computation of the Percentage of Permanent Disability in Eye Injuries, Under the Employers' Liability Act," by Dr. Elbert S. Sherman, of Newark.

Dr. Sherman presented his communication.

This paper was discussed by Drs. C. H. Schlichter, Edgar Holden, T. R. Chambers, C. W. Crankshaw, Elias J. Marsh, W. B. Johnson, J. B. Hagerty and W. M. Goodwin.

For Dr. Sherman's paper and the discussion thereon see a subsequent issue of the Journal.

President Hunter: That closes the discussion. Now I am going to ask Dr. Carrington to read this letter to the meeting.

Dr. Carrington: On behalf of the doctors in the southern part of the State, I want to say the only industry we have down here is hospitality, and we don't get hurt extending hospitality. The letter that Dr. Hunter asks me to read is from the Leeds and Lippincott Company. Dr. Carrington read the communication, inviting the Society to make their headquarters at Hadson Hall during next year's annual meeting.

President Hunter: Now, gentlemen, if there is nothing else to come before this session, a motion to adjourn is in order.

Dr. Chambers: I move that we adjourn. The motion was carried.

General Meeting.

SATURDAY AFTERNOON SESSION.

June 23, 1923.

President Hunter: The meeting will come to order.

Dr. Pollak: Mr. President, I arise to a question of personal privilege. I should like to ask this assemblage to grant the privileges of the floor this afternoon to Dr. Lynn, of Paris. I so move.

The motion was carried.

President Hunter: I desire to announce that Dr. Lynn has the privileges of the floor.

The first item on the program for this afternoon is the "Oration in Surgery," by Dr. Samuel Goodwin Gant, of New York.

This oration was discussed by Drs. A. H. Lippincott, David A. Kraker, Berth. S. Pollak, C. F. Underwood, C. B. Kelley and S. G. Gant.

(See September Journal for this oration and the discussion of it.)

President Hunter: Gentlemen, I feel we all deeply appreciate the kindness and courtesy of Dr. Gant for coming down and addressing us today, and as a token of that appreciation I am going to ask you all to give him a rising vote of thanks.

A rising vote of thanks was extended to Dr. Gant for his splendid address.

The General Meeting adjourned at four-thirty o'clock and the meeting of the House of Delegates then took place.

House of Delegates.

The meeting of the House of Delegates convened at four-thirty o'clock, Dr. James Hunter, Jr., President, in the chair.

President Hunter: Unfinished Business comes up first. Is there anything under the head of unfinished business to come up at this time? Hearing that there is no unfinished business, the next item is the Report of the Business Committee.

Dr. Weeks: The Business Committee has had a most wonderful vacation this year. There has been nothing referred to it.

President Hunter: Now we come to Miscellaneous Business, and I think under that head formal votes of thanks should be extended for the various courtesies extended.

Dr. Pollak: Mr. President, I move you, sir, that the House of Delegates hereby passes a resolution of hearty appreciation and thanks to the management of the hotel; to the Committee on Arrangements, and to the gentlemen of the press; that we appreciate their graciousness in co-operating with us and in helping to make this a most wonderful meeting.

The motion was unanimously carried.

President Hunter: Is there any other item of business to come up at this time?

The Report of the Board of Trustees. In the absence of Dr. English, Dr. Morrison will read the report.

Dr. Morrison read the Report of the Board of Trustees.

Final Report of the Board of Trustees.

A meeting of the Board of Trustees was held at 12.30 o'clock, noon, on June 23, 1923. In the absence of Chairman Sproul, Dr. E. J. Ill was elected chairman pro tem.

The Secretary read the following petition signed by a large number of the delegates present at this annual meeting.

"We the members of the Medical Society of New Jersey respectfully petition the Board of Trustees of the Society to establish a small annuity for Dr. William J. Chandler, our retiring Recording Secretary, as an evidence of our appreciation of his long and faithful service."

After discussion the Board unanimously voted that an annuity of \$500 be paid by the Treasurer of the Society to Dr. W. J. Chandler during the first week in January each year.

On motion of Dr. W. J. Carrington, the Corresponding Secretary was authorized to purchase a steel cabinet for the records of his office at the cost of \$73.00.

Dr. W. P. Eagleton offered the following:

Resolved, That the Delegates of the Medical Society of New Jersey to the American Medical Association be instructed to use their influence and votes to dissociate the Editorship and General Management of the Association, placing the Editorship entirely separate from the General Management of the Association so that The Journal may represent solely the scientific and ethical side of the American Medical Association, and that they use their influence and vote that an ad interim meeting of the House of Delegates be held at the Headquarters of the Association. As a Delegate, you are instructed by the Society to use your influence and vote for the above.

It was unanimously adopted and a copy was ordered to be sent to our Delegates now in San Francisco.

D. C. ENGLISH, Secretary.

Dr. Weeks: I move that the Report of the Board of Trustees be received and the recommendations adopted.

The motion was carried.

The following is the report of Dr. W. J. Carrington of the attendance:

"Out of seven officers of the State Society, six attended; of the trustees, twenty out of twenty-eight were present; three out of five councilors were present. There were 117 permanent delegates registered; 44 annual delegates, 142 associate delegates, 279 guests, 31 doctors from outside of the State, representing as follows: Pennsylvania, 13; New York, 9; Ohio, 3; Delaware, District of Columbia, Maryland, Texas, California, Canada and France, 1. There were eighty-six exhibitors. This last item does not mean that there were eighty-six different exhibits, but that eighty-six people, connected with the exhibit, were not registered as guests."

President Hunter: Is there any other business to come before the House at this time? If not, I am going to ask Dr. Eagle-

ton, the President-elect, to step to the platform for a moment.

Dr. Eagleton, it is with deep respect and appreciation of your long and faithful services to this Society, and with a personal feeling of pleasure and deep admiration for your ability and reputation as a surgeon, of which this Society is justly proud, that I, as the retiring presiding officer of this Society, now transfer to you this gavel, the symbol of honor and authority, which the Society now bestows upon you with full confidence that it will at all times be used by you for the best interests of this stately, old Society—the oldest medical organization in America!

Dr. Eagleton accepted the gavel amidst applause.

President-elect Eagleton: Mr. President and Members of the Society: I haven't any speech to make, but I want to tell you something that has occurred. Of course, it is customary, when a man is elected President, to say that he will do the best he can; and he does. But it is a little different with me because all my life, ever since I have been twenty-one, I have been assuming responsibilities with a very easy heart; I am built that way. I have been handed many jobs, or I have gone after them, and if I got them, I went home and slept well, and I thought it was all right.

However, once in my life I woke up and found I had a job that I didn't know what to do with, and I was frightened; and that was when I entered the Army. I didn't know what in the deuce I was to do. I wasn't a soldier! And then suddenly I was drawn in. They kept me standing around for a long time after I was commissioned, and then suddenly by telegraph they ordered me to go—and I went. They told me that the troops were going to come in. The following week, I wondered what in the world I was to do. And it kept me awake that night, and for a long time afterward my job worried me terribly. Outside of that, until today, I do not remember ever being frightened over a job.

I was going home this afternoon on the three-fifty train; I had planned to take it and had my ticket purchased, when suddenly I woke up this morning—frightened; and I have been frightened all day. I cancelled my reservation and decided to stay down here until tomorrow. I said, "I have gone through these offices." You know how I was elected. Some years ago I came down to the State Society and I had the wife of a Newark physician in my care. I had operated on her and she suddenly de-

veloped a very high temperature, and I thought she was going to die. I came down to the State Society and got frightened and ran back home to see her, and she was doing better, and I came back the following day, and, much to my surprise, I found I had been elected Third Vice-President. Of course, that didn't worry me. I thought that was a very nice thing, and I was delighted about it.

So I have gone through the three offices—Third Vice-President, Second Vice-President and First Vice-President, and there has been nothing to do. I thought it was kind of a lark! But suddenly this morning at about seven o'clock I awakened to the fact that I had a job on my hands, and I didn't know exactly what to do with it. However, the members of the medical profession of New Jersey were looking to me to not only carry on the honorable traditions that we have had for one hundred and fifty-seven years, but they were looking to me as their President, as they do to every President, to make good—and it has frightened me!

I am not ashamed of saying that I am frightened—I am! I spent all day talking to this one and that one, as to who were the men whom I should appoint on these various committees, which men would work; who would do this and that; and the more I talked, the more I realized that the presiding officer of the Medical Society of the State of New Jersey has a grave responsibility upon him; and all I can say is that I ask your help, everyone of you! I am an impetuous man. All my life I have been making terrible mistakes, and all my life I have been going home and thrashing around till two and three o'clock in the morning, trying to think what the best way was to get out of the hole I had gotten myself into. I am fat, but it isn't due to the fact that I am a good sleeper, for I am not.

Now I am frightened. I ask you, every one, to give me your assistance and to believe this: That I am sincere in my desire to serve you all, and I ask your help. If I can succeed in making the next year as successful a year, and the next annual meeting as successful as this, and treat everybody as fairly as Dr. Hunter has, I shall feel that I have been more than a success. (Applause.)

President-elect Eagleton* took the chair.

President Eagleton: As President of The Medical Society of New Jersey, I declare this meeting closed.

The meeting adjourned at four forty-five.

ADJOURNMENT SINE DIE.

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NEW THEORY AND PRACTICE OF OBSTETRICS.*

By **James M. Hackett, M.D.**

Leonida, N. J.

Dilatation of the Cervix Uteri Podalic version and delivery of the child under surgical anesthesia when the progress of accouchment is delayed beyond two to four hours from any cause except in cases that must be delivered by caesarean section.

In my first paper on this subject which I read before the Vermont State Medical Society at Barre, Vermont, in 1917, I reported two hundred and fifty cases delivered by the above method. I apologized for presenting a paper advocating the rapid delivery of woman by dilating the os and version under anesthesia in slow cases of labor from any cause when all the world seemed to be content to let human nature take its course. At that time I had not seen or heard a report on this subject from any obstetrician. In the discussion I received criticism for interfering with nature's course, however, the absence of maternal mortality and the low percentage of infant mortality in my report was highly commended.

I began this method of dilatation of the os, version and rapid delivery under anesthesia in 1902 on cases of accouchment which I felt free to experiment upon, but not until 1907, after a sufficient number of successful cases proved to me that this method was a life-saver, did I begin regularly to practice this method and keep a record of cases. From 1907 to 1918 I delivered two hundred and fifty cases after this method with the remarkable result of no mortality and only two

per cent. of infant mortality. With this record I read my first paper advocating this method of delivery in all slow or delayed cases of labor except such cases as called for delivery by Caesarian Section. In advocating this method of procedure for the relief of women in perils of childbirth, I wish to make the statement here and now, before the Medical Society of New Jersey, that the time has arrived, yea, it has even long since past, when we, as physicians, surgeons, and obstetricians must assist women in the perils of childbirth much more promptly than has been the custom from time immemorial. The perils of childbirth alluded to are those long continued cases that end only after twenty-four to forty-eight hours by instrumental delivery and occasionally terminate fatally for both mother and child. These are the cases for which I offer a new theory and practice by the method of dilation of the cervix uteri; version and delivery of the child during the first two to four hours of labor or as soon as you can determine that your case requires assistance. The causes of these long delayed cases of confinement and alleviation for such cases will be fully explained after we have considered a normal case that does not require assistance; and certain conditions in the human family that lead up to the serious conditions of abnormality that does require the scientific assistance of a competent obstetrician. There is no danger to the child or mother in a normal case of confinement and very little acute suffering if the act of expulsion of the head of the child is carried over the perinaem by the aid of moderate anesthesia.

By a normal confinement I have in mind a woman of womanly conformation anotomically (picture) recall for the moment the perfect conformation of a fe-

*Read at the 157th Annual Meeting of the Medical Society of New Jersey, at Atlantic City, June 22, 1923.

male figure, a well-developed physical system and a well nourished body. There is inherent in every normal human being that in acquiring a mate they are attracted to the opposite sex by beauty of face, a well developed body that is supple and graceful in motion. "This is equally true of both sexes." History tells us it was ever thus. King Phillip II of Macedonia, 340 B. C. visited the Island of Samothrace to witness the athletic contests which were very popular in those days. There he beheld Olympias, the daughter of the King of Epirus, taking part in the athletic contests and dance. The confirmation of her body was perfection, her strength marvelous and every motion of her body compelled admiration. These people had reached a very high standard of physical development. King Phillip was infatuated with her and married her. From this union came Alexander the Great and Cleopatra, both marvelous specimens of humanity.

Today what inferior physical constitutions do we occasionally have to minister unto namely. The little woman weighing less than 100 pounds, the short fat woman, the large woman, with a male pelvis, the idle rich and the smoker with very little muscular development and a weak, flabby constitution. These are the ones more particularly that require help during child-birth. I believe that there should be a physical standard to which men and women should qualify before indulging in matrimony, if this nation is to endure. All males are not as discriminating as King Phillip.

Notwithstanding all the departures from normal in conformation among would-be mothers, it is my experience that the most common cause of protracted cases of confinement is due to the failure on the part of human nature to provide a normal bag of water, one that will gradually come down as labor pains begin, force into the os uteri with membrane good and strong and with ever increasing pressure from contractions of the Uterus above; this bag of water within the os should perform its function of dilatation of the neck of the uterus in from two to four hours, and permit the head of the child to come through it into the pelvis. In such cases there is no delay.

Picture to yourselves the child suspended in the bag of water, thoroughly

protected from pressure, until the head of the child is in the pelvis cavity, and the bag of water appearing at the vulva is suddenly ruptured, a volume of water passing out the uterus gathering strength as it come down, the head of the child is swept over the perinaem without any injury from pressure. How often are we disappointed by this bag of water that fails to perform its function? The filmy membrane has ruptured. The waters have leaked away or come away with a rush before labor pains begin. There is very little, if any, water in the uterus.

Nature does not intend that the head of the child should dilate the os uteri in childbirth and it should not be required to perform that function at the expense of injury to the head of the child. It is a substitute however, for that purpose, wisely provided by nature and while in the majority of cases it will perform that function within a reasonably time, in a minority of cases however, it will require many hours which will endanger the lives of both mother and child. Other conditions which require assistance by this method are cases of acute Brights; all cases of rigid os or prolonged parturition from any cause. The pressure to dilate the os should come from within the ring, not from above. When you find this condition present of the head of the child trying to dilate the os, and progress is slow and very painful, do not wait beyond two to four hours before supplying a substitute where human nature has failed. This is best supplied by dilatation and delivery of the child by podalic version under surgical anesthesia. Should you wait beyond two to four hours when the pains are regular and strong, the waters are apt to come away which will make version more difficult to perform.

Childbirth is entirely a mechanical procedure, therefore, why should the delivery be delayed, until your subjects are in danger of death. Do you know that today female animals fare much better than women under the same conditions. Veterinary surgeons will assist and deliver an animal as soon as delay from any cause occurs. He knows that there is danger of losing the animal when there is delay. I believe the one thing above all others that has been the direct cause of maternal and infant mortality in cases of childbirth has been the phrase, "Let Nature Take its course" which has been handed

down from one generation to another on obstetrics, from time immemorial and has had a strong tendency to hold back the necessary assistance that should have been given to women in difficult labor in order to save life. There never has been a graver offense committed in the course of human events than the application of these words, "Let Nature Take Its Course," when applied to govern the procedure of the delivery of a woman in labor.

These words aptly apply to the great wonders of Nature, viz: the returning of the seasons, in which Nature does take its course, when you apply this phrase to poor weak, imperfect human nature, lying before you in prolonged agony of childbirth, note if there is anything in this terrible plight analogous to the return of the seasons. I wish to state here that the phrase, 'Let Nature Take Its Course' when applied to the woman in the perils of childbirth is as vicious as Hell. We must emerge from behind the screen of inefficiency and when we conduct a case of childbirth that does not progress accordingly as nature intended, do not wait beyond two to four hours before you convert the case to the surgical side and proceed to deliver by dilating the os mechanically and version. It is those cases that end in tragedy on account of long delayed delivery that this method obviates by prompt delivery by version. This new theory and practice in such cases as require the scientific aid heretofore denied the suffering woman is bound to come, therefore let us be adequate. The great progressive spirit of woman's clubs are today inquiring and they will not much longer be denied.

Of the 500 cases of which I have a record 250 of these cases were delivered by dilatation of the cervix and version. This record shows that fifty per cent. of all cases should be delivered by this method in order to secure the best results. This percentage would vary somewhat no doubt. Two hundred and fifty of these cases, viz: Fifty per cent. of all the cases, were delivered by dilatation of the cervix and podalic version. There was not a single case of maternal mortality among the two hundred and fifty difficult cases and only two per cent. of infant mortality. None of these difficult cases (called slow or delayed cases of childbirth) were allowed to suffer beyond one

to three hours. With this experience I say it is worth while, to assist women in the perils of childbirth, and by the use of this method among obstetricians, if the lives of mother and children are saved; long suffering and perils of childbirth are overcome. We shall have contributed to the science of obstetrics. The course of procedure of delivery as developed during this experience (in approximately 300 cases) of version, and is the same as given in my first paper read at the Vermont State Medical Society in 1917.

We will assume that the patient is in the first stage of labor, that an affective enema has been given, that catheterization has been performed, that she has been shaved and washed and cleansed with an antiseptic solution. With a long glove on the right hand and a short one on the left, if we find, on examination, that the os is open about the size of a ten cent piece; through the os you feel with the tip of the index finger the child's head flat against the os and there is no bag of waters protruding into the os, history of the case may be that the waters have leaked away during the day or night, or that they came away with a rush before the pains really began. We will assume that the labor pains are coming regularly every five or ten minutes and are producing considerable distress. We have the patient walk about the room slowly, stopping altogether as the pain comes on, grasping a chair or table during the pain. We allow this to go for one hour, during which time the pain has increased in length and severity. On examination, again, at this time, we find very little, if any progress so far as opening of the os, although pains are quite severe and it becomes patent to you, as an observer, that you are in for a hard sickness and possibly a long confinement, for the reason that the os is being dilated by the head of the child, of which the principal is entirely wrong. No bag of water has come down to perform dilatation and we must supply that which human nature has failed to do in this case, that is, to supply version.

Accordingly, chloroform is administered on the bed or table. The patient is well under, almost to surgical anesthesia, and with the right gloved hand, well smeared with vaseline (prepared) insert hand into the vagina with the four fingers extended close together, thumb in the middle, form-

ing the shape of a cone. In a multipera it will pass in readily, a little more time will be required in a primipera. The subject at this time should be in a state of surgical anesthesia, while your hand is in the vagina you are to make an important deduction: By opening your hand to the fullest extent possible, you measure the size of the pelvic cavity. The application of this mental deduction will be of much benefit when you hold the head of the child in your hand later. Now we proceed at once to dilate the os uteri with the fingers and thumb until you can slip the hand through the os into the uterus. The ease and expertness by which the act of dilatation is accomplished depends largely upon practice and strength of the fingers and thumb. Do not dilate the os rapidly, thus avoid tearing of the neck of the womb. The first inch is the most difficult to gain, the second inch considerably easier, thereafter it is comparatively easy by using the same position of the hand as described on entering the vagina.

Before beginning this last step of inserting your hand into the uterus, held in the position described, on entering the vagina place your left hand on the abdomen of the patient, over the fundus of the uterus, and make counter pressure from above, the force of which is to correspond with the amount of pressure you are making from below with the right hand. On entering the uterus, take the head of the child in your hand. Note the size of the head. If the head is abnormally large and you decide that it will not pass through the pelvis, withdraw your hand and prepare for caesarean section.

If you decide it will pass through, push your hand up along the left side of the uterus, find the legs and feet of the child. If the membranes are still unruptured at this time, which is very desirable, you will rupture them and grasp the ankle of the child just above the foot. Endeavor at this point to secure both ankles in your grasp, for if you have both legs coming down together it will somewhat facilitate delivery. However, it seems impossible to secure both, you will grasp one securely and make traction downward. At this point remove the left hand from the fundus and with it make upward pressure just above the symphysis pubis, to assist in the act of version. When the foot of the child appears at the velva, ver-

sion is complete. During the act of version, it is important by the aid of one leg or both, to rotate the body of the child so that the back of the child will be uppermost under the symphysis pubis. As soon as the feet or foot appears, wrap a dry towel around it in order to have a better hold by which to make traction. Do not try to get the other foot until the breech is delivered after which it is easily recovered. Wrap the legs and body of the child in dry towels as fast as it appears in order to protect the child and give you better control in holding the child. When the shoulders are about to be delivered, slip two fingers of your right hand over the right shoulder of the child, swing the body of the child to the left and deliver the shoulder and arm. The left shoulder is delivered in the same way, using the fingers of your left hand to accomplish the act as before. This accomplished, grasp both shoulders of the child with your two hands and make traction in order to set the head of the child well down into the pelvis. This is very important to facilitate the delivery of the after-coming head, which is to be delivered as quickly as possible by the accepted method of carrying the body of the child upward on the abdomen of the mother, thereby using the pubes to a certain extent as a fulcrum to aid in the delivery of the head. Should the head stick at this point, do not exert extra force on the fulcrum of the pubes, but rather pass the index finger of the left hand into the vagina, posteriorly hook the index finger into the lower jaw of the child, making traction downward. This suggestion will assist very materially in the delivery of the head, especially in primiperas. Should you fail to deliver in this way, use the forceps on the after-coming head. It is important to deliver the head as rapidly as possible to save life.

I have not been obliged to resort to forceps in any case of the after-coming head. The amount of time usually required to perform this operation is from ten to thirty minutes. The amount of chloroform used, from one to four drachmes.

With this method the time usually consumed at a confinement is from two to four hours, very rarely six hours. A point to which I would particularly call your attention is the great satisfaction on the part of the family of having the sick-

ness over within a short time. Of these two hundred and fifty cases, there was not a maternal death and the injuries to the soft tissues of the mother were nothing in comparison to the injuries ordinarily sustained by the use of forceps. The period of involution is much shorter and convalescence more rapid due to the elimination of shock that is experienced by patients enduring a long first and second stage of labor followed by instrumental delivery. By the adoption of this method the number of forceps operations are lessened, thereby eliminating serious injury to the child's head.

CONCLUSION

This procedure should be more often done to shorten time of labor, lessen shock to the mother and eliminate pressure on the child's head.

That dilatation and version can be readily accomplished in primipera, and should be more often done.

That foetal mortality by this method is not as great as in prolonged cases of instrumental delivery.

The head injuries to the child are also very much lessened if not entirely so.

The classes of cases to which this method is particularly applicable that have come to my knowledge are acute Bight's threatened with eclampsia. All cases of rigid os. All cases in which the head of the child does not engage at the superior strait (in preference to the application of forceps) and all cases wherein the bag of waters fails to perform its function.

I wish to commend to the profession at large this method of procedure as being not only a life saving method but also as being the greatest penance to woman-kind that has as yet been brought to light.

Oh woman, rejoice, the hour has struck in this, the twentieth century of the Christian Era: By the ingenuity of man, the perils and pain of childbirth have been overcome. No more in sorrow shalt thou bring forth. In the good physician thou has a friend indeed.

DISCUSSION.

Dr. William J. Harman, Trenton: In the first portion of Dr. Hackett's paper he speaks of a delay of two to four hours in progress of accouchment. I might ask is this from the beginning of labor or after full dilatation of the cervix takes place? I have performed thirty versions since January, 1922, only after full dilatation or an easily dilatable cervix has

taken place. I limit version to malposition—transverse R. O. P. moderately contracted pelvis. Dr. Potter of Buffalo advises against version until full dilatation has taken place; also never to do podalic version where the amniotic fluid has drained away, thereby placing the patient in danger from a ruptured uterus. I must acknowledge I have several times been unable to deliver with forceps and was compelled to do version with unexpected and easy delivery of the after-coming head.

We all realize one more important point besides unruptured membranes, of the advantages of a well moulded head of the fetus. Has Dr. Hackett found that such short duration of labor gives his babies this factor, which alone gives the patient a normal labor much to our surprise when we have expected a difficult delivery. My records show ninety per cent. normal delivery, labor lasting from two hours to twenty-four hours. Our surgeons at St. Francis Hospital, Trenton, requests no vaginal examination or only one with sterilized rubber glove, if the case is expected to have caesarean section, on account of the dangers of infection. Decision for caesarean section resting on pelvic measurements and entrance of fetal head into pelvis after a sufficient test of labor. I hesitate to criticize any method of delivery, since DeLee's rapid forcep delivery, Potter version, Caesarean Section, rapid dilatation of the cervix have come into vogue. Personally I believe in the normal test of labor before any interference following the statistics of the New York Lying-In Hospital, which shows that within the group of ten per cent. complicated deliveries the number being 4,000, version was performed, in 3,200 cases the remaining 800 caesarean, forcep, etc.

Dr. Charles P. Noble, Philadelphia, said:

So far as the paper which has been read to you is concerned, I have this to say: It was evident that the writer of the paper was in earnest, and that we can all heartily commend. Earnestness and sincerity are great virtues, though in my judgment, they may be misdirected. Speaking generally, for I shall not discuss the paper in detail, I would say that I disagree with the reader of the paper very largely. As he was sincere and earnest, I shall endeavor to speak likewise. My knowledge of obstetrics dates back to the time when I was a senior medical student in Baltimore, in the winter of '83-'84, which is now approaching forty years. At that time the wisdom of the fathers and the teaching of the ages was received with respect. No one who taught in that day assumed that wisdom was born with them. Tradition, age-long knowledge, and proved experience were considered more reliable guides than the personal impressions of any individual. That teaching I received and a long experience in practice has confirmed, to me, its value.

So I would discuss this subject from a broad viewpoint, from the point of view of the tendencies in obstetrics during the past forty years and the influences which have brought about what has happened. Forty years ago the discoveries of Pasteur had scarcely made their full impression upon the medical mind, and the practical application of those discoveries by Lister were being introduced. In other words, that was the era of antiseptic

surgery. When these principles were first introduced in obstetrics, which was in my early experience, because during the first five years of practice I was connected with an obstetrical hospital, I was the first assistant in the Philadelphia Lying-in Charity, where the traditions of the fathers, as well as what had been learned by personal experience, were carried out by the late Albert H. Smith and the late Elwood Wilson, both of whom are sound practitioners. When the principles of antiseptic surgery were first applied in obstetrics and particularly a little later, when asepsis was first used in obstetrics, as these were surgical measures, that naturally gave a surgical slant to obstetric thinking.

The application of aseptic principles in obstetrics was all to the good. It made normal labor safer for both mother and child. It also made surgical obstetrical operations safer for both mother and child. This was all to the good. But, unfortunately, it not only made operations, which should have been done, safer, but it also made operations safer, which could be done, and that was the next stage, and that is the stage in which we now are.

We know that during my life's experience has been the surgical era, and many of you know that I was a part of it. So that I am quite aware of what was good in it and am equally familiar with what has been bad in it, and in obstetrics what has been bad in it has been what could be done without mortality, which was not necessary. It is a sound principle that no interference should be undertaken, surgically, which, with equal advantage or safety to the patient, can be accomplished without surgical interference. That is just as true in obstetrics as it is in gynecology or any other branch of medicine. As I said, I intend to discuss this subject on broad principles and not in detail.

Now to come down to the recent past: First, according to the classic indications of various obstetrical operations, these indications were broadened properly, because prior to the antiseptic and asepsis, the maternal mortality was so high that good sense required the restriction of such operations. But as they became safer, the line of reasoning naturally altered, as the premises were altered, and so among other things Caesarean section was done much more frequently than in the past, and properly so.

I shall not discuss the fine points, as to just how broad and inclusive these indications shall be, because that is going into details. But speaking generally, I feel that the broadening of the indication for Caesarean section has been proper, although I believe that in certain hands, in the hands of men who are rash, men who are nervous, men who are always in a hurry, who don't understand the value of time and what judgment and patience and management will accomplish, I have no doubt that more Caesarean sections have been done than were necessary, but that takes in details. Now to come further, we have before us today two lines of teaching in obstetrics. One is fathered by Dr. Delee, in Chicago, because we are talking plainly, and so we will use names. The other is fathered by Dr. Potter, in Buffalo. So far as

the actual work of these two men is concerned, I am in the position of the man who was given the book to review, who said that he could review it without prejudice, as he had not read it. (Laughter.) I have not seen either of these gentlemen at work, and I state that frankly, so I am discussing it on general principles and not from personal observation.

So far as Dr. Delee's work is concerned, the impression that it makes on me is that it is altogether bad. I do not mean that he is a bad operator; I believe he is a very good operator. Unfortunately for his patients, he is so skilful that he puts it over, and so a process which is natural, which is just as natural in a human female, as it is in any other mammiferous female, is turned by him into a major surgical operation. That violates logic; it violates science, and, worst of all, it violates common sense, and it is to be hoped that the medical profession has not lost that, because that is the most valuable possession that any body of men can have. I do not know anything about the Delee teaching, which appeals to me as being good. That is an extreme statement, and there is no doubt that extreme statements are somewhat open to question, and, perhaps, if I visited Dr. Delee's clinic I would see something which would cause me to modify that; but still it remains true that as a teaching, as a practice, as a policy, to turn a natural physiological process into a major surgical procedure is nonsense, and worse.

So far as Dr. Potter is concerned, there is every reason to believe that Dr. Potter has taught the profession a good deal about the technique of podalic version, and no matter what happens to the Potter teachings, as an outgrowth of it, the profession will be enriched by whatever Dr. Potter has learned and passed over, as to the technique of podalic version. So that is to the good. But otherwise what I have said about the Delee procedure applies just as well to the Potter procedure, because, unless the baby arrives before Dr. Potter gets there, there is either a podalic version of a Caesarean section.

In spite of that fact, a good many babies arrive before Dr. Potter does. In other words, in spite of the reader of the paper, nature has not forgotten her job among the women, and even with the most earnest gentleman, such as Dr. Potter is, the babies will arrive, or the mothers' dynamic energies will make them appear in the world, unless the doctor hurries up, in many cases.

There is one other aspect from which I will say a few words, and then I am through. I was educated before the present era, when the ethics of gentlemen and the ethics of the medical profession were held in high esteem, and when economic advantage was not taught to doctors, as being the summum bonum. You see, we are talking plain English today.

Dr. Edward J. Hill, Newark: Mr. President, a paper of this kind invites criticism. A great many years ago there was a paper read before this Society on "Rapid Dilatation of the Cervix." At that time I said rapid dilatation means injury, means lacerations, and often enough, very extreme lacerations. I have been able for a great many years to foretell, by the examination of the patient,

what sort of labor she has had, and those who have been with me in the hospital work know how well we can foretell that sort of thing. I am very sure when we change a normal condition into an abnormal one, that we are going to injure the woman.

Some years ago, when Dr. Potter first read his paper, I think it was in Cincinnati, on "Podalic Version," when he reported 500 cases, I was asked whether the Society should publish in its transactions such a paper. I said: "Yes, by all means. The man is an honest man. Let us go and see what he does." And to this day I think Dr. Potter is an honest man, just as I think the reader of the paper is. It is his view of things. But we must follow a case up, of this kind, and see what the ultimate results are. I went up to see Dr. Potter. I saw him deliver eight women in two days by podalic version. He is a master, and everybody knows it; and we have a great deal to learn from him. But he never delivers a woman by version before the cervix is fully dilated and properly contracted, a very important thing in this work.

Of late my friend, Dr. Hayd, of Buffalo, tells me that 10 per cent. of his cases, in which he does not do a version, he does a Caesarean section. I do not know of any obstetrician, 10 per cent. of whose cases need Caesarean section. That is one bad side of Potter's work. The reader of the paper says the same thing. When he cannot bring the head down with his hand and make it fit into the pelvis, he does a Caesarean section. There is no occasion for that at all; it is against all teaching and experience, for we remember how well and thoroughly the head may be molded to a pelvis. A very important consideration that the doctor gives to his paper is that of a labor that has lasted from two to four hours. Gentlemen, there is no such thing as two to four hours in labor. It is the condition of things that determines what we shall do, not the time. I think most of you bear me out in that.

I wonder, among the 250 cases that he delivered by podalic version or during that same time, how many cases of Caesarean section he has done. I trust when he comes to discuss our discussion, he will tell us how many Caesarean sections he was obliged to do. Two hundred and fifty cases mean nothing. That is too small a number.

It is just as well for us, as doctors, to know that the bad injuries do not come from midwives; they come from ourselves. I have always, for that reason, upheld the midwives. We have more septic cases among our cases than the midwives have. For instance, when I read a paper one time at the Sloan Maternity Alumni, they told me that 87 per cent. of all the septic cases that entered Beth Israel Hospital were from doctors and 13 per cent. from midwives; and the East Side of New York has more cases attended by midwives than by doctors. Why? For the same reason that the doctor does his version. We interfere entirely too often, entirely too much. Lastly, in the doctor's paper, he considers the cervix to be the alpha and omega of all obstruction. There are a great many other considerations besides the cervix. I agree that the cervix is an important part in labor, but

it is not the beginning and the end of true labor. Thank you. (Applause.)

Dr. Charles F. Underwood, Newark: Mr. President, I would like to disagree with the reader of this paper in one of two respects. In the first place, I do not believe from two to four hours should be considered as the time in which we should interfere. It seems to me that the time in which we should interfere should be governed by the fact that the cervix is either dilated or dilatable, and our cervical lacerations will be less. Another thing: From this paper we are led to believe we should hurry. I think hurrying in a version is one of the greatest mistakes. I believe more babies have been lost and more mothers have been injured by hurrying in a version, than perhaps from any other cause. There are one or two things in the technique that I think might be mentioned to our advantage. One of them is that after inserting the hand, the hand should be passed up along the back of the child and the arms drawn down across the chest in this manner (indicating), which will make the delivery easier, make the injury to the child less apt. Another thing in the technique, which I think would be to our advantage, is not to deliver a shoulder posteriorly; deliver the shoulder first that comes anteriorly, then turn the child and make the other shoulder anterior. It will lessen lacerations.

Dr. George E. Reading, Woodbury: Mr. President, I can only speak upon this from strictly the standpoint of the country doctor, for that is all I am, and all I ever will be; but as all country doctors who have much practice we get a good deal of obstetric practice, because out in the country if you attend a family for other things, you must attend them when there is a baby coming. If you don't, you lose the family. Those of you who practice in the country know that that is a perfectly true statement. But I have been taught, and I have followed it out now within one year as long as Dr. Noble, I graduating in '85, that while nature was taking care of the case properly, the doctor had no business to interfere, regardless of whether it takes two hours, four hours, six hours or twelve hours, or twenty-four hours. It is his business to give the necessary time, and just so long as nature is doing her work properly and there is no danger of injury to the child, and the mother is in good condition, he has no right to interfere. That is the teaching that I have followed, and after thirty-eight years of experience along that line I still maintain it is the proper one, just as (to get off the subject a little bit) in taking care of a woman before labor, when a patient comes to me and engages me for an obstetric case and asks me what she shall do, I say: "It is all summed up in just two words—keep well!" And that is all there is to it. If the mother is well, there is going to be no trouble. If she is not well, then step in and remove the obstruction, whatever it is. The same is true in labor. Just so long as nature is following out her proper plan and the mother is in good condition, it is criminal to hurry it up, just because you may have another case around the corner, or think you are going to have. If you can't give the case the time

that it ought to have to terminate naturally, you ought not to practice obstetrics. That is the experience of thirty-eight years in country practice. (Applause.)

Dr. Augustus J. Mitchell, Newark: I would just like to ask one question, namely, whether he thinks it is good surgery, after having his hand greased with the vaseline in dilating the cervix and then doing the Caesarean section afterwards?

Dr. Hackett—Closing—I will answer the last question first. I have never done a Caesarean section. To the gentleman over here I will say, regarding the delivery of shoulders, it is a thing that comes down without your assistance. The other two gentlemen, whose criticism I thank them for very much, evidently are not acquainted with this method. My method differs from Dr. Potter's materially in the fact that he does not dilate the uterus and I do. I will read you a case here:

"Case 1. Mrs. W., age twenty-eight; primipara, L. O. P. presentation forty hours' dilation, performed version, delivered an eleven-pound boy. Took about twenty-five minutes; child alive and mother got along nicely."

My process differs from his absolutely and entirely, because I believe you would have to open the cervix in order to get the baby. This paper, of course, applies more particularly to the cases that I spoke of in conclusion. In cases of Bright's disease, with threatened eclampsia, I don't think there is any gentleman in this audience who would sit around and wait for the woman to be delivered herself. I hope not. Now I would like to ask them what they do in the case of rigid os? Do they sit around and wait for a rigid os to dilate? If they sat around and waited for a rigid os to dilate, they would be there until next week, and they would lose both the mother and child.

Those are two special cases in which this practice is particularly applicable. The ordinary case, as I said in a very few words, needs no help. You can sit around and wait, and the thing is all right, but it is when the case presents difficulties that are going to threaten the life of both mother and child, that we are coming to relieve them. If the record of 300 cases, with no maternal mortality, is not pretty good, I would like to ask what is? I have seen cases where both the mother and child have been lost at the end of twenty-four hours. So it is these difficult cases that we are trying to help. We don't expect much support and assistance from the older doctors, but it is to young men to whom I look to get on the job and relieve a woman who has been suffering from twenty-eight to forty-six hours. You can sometimes deliver a woman in ten or fifteen minutes, and she will come along fine. I only delivered one woman in Hackensack Hospital, with which I established a record. She was a stout girl, eighteen years of age, and weighed 250 pounds. Inside of one hour I delivered her. The pains were just established. The third day she sat up; on the fourth day she walked around the hospital and felt fine; on the seventh day she went home. Contrast that with waiting for that short, stout girl to deliver

herself, suffering from thirty-six to forty-six hours.

I think any man would agree with me that the bag of waters, if it is normal, will come down and dilate that os inside of four hours. That is my experience, and I have had only 1,600 cases myself, from which I am judging. I think it is a mistake for anybody to throw cold water on something which is designed in an endeavor to help women. We are trying to save lives. Some of you say to let the woman take care of herself, and if it were all normal it would be all right, but things are not always normal in obstetrics, as you know; the bag of waters is not normal in more than 50 per cent. of the cases.

Dr. Keller: Where does the doctor draw the line of a normal case? He seemed to lay great stress on two to three hours' time. We all know that in eclampsia cases and in these difficult cases, you dilate and deliver; you do not wait fifteen minutes. But it seemed to me the paper stressed that a woman should not suffer that pain from two to four hours. I claim a woman can have labor pains for twenty-four hours, as long as she is in good condition.

Dr. Hackett: They don't enjoy it; they want this thing over. If there is no bag of waters to dilate the uterus and they have to wait twenty-four hours to dilate the uterus they will come along out. I think two to four hours is long enough, because your case is either going to progress or not progress at the end of that time.

LUMBO-SACRAL BACKACHE*

By B. FRANKLIN BUZBY, A. B., M. D.
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Of all the symptoms which we as doctors are called upon to determine the cause, I know of none which is more troublesome than lumbo-sacral backache, and since it is so common I feel that a plea for more careful and complete examinations is not out of place.

The causes of backache in this region are so varied that I shall divide them into five general headings: (1) Congenital defects in the spine and pelvis; (2) abdominal diseases, including the genito urinary tract of both men and women; (3) traumata; (4) metastatic diseases and influences, and (5) abnormal posture or static backache. All cases are not easily put under one of these headings, for often two or more causes may be operative, and both require correction. Due to exposure to trauma, low backache is more frequent in men than in women, and it may begin at any age.

(1.) Of the congenital abnormalities

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the one most frequently encountered is some defect in the fifth lumbar vertebra. Since anomalous conditions are more frequent in regions where structures have undergone transition, this portion of the back shows more evidences of maldevelopment than any other part of the body. Many of these changes are discovered by chance in a X-ray examination and present themselves as causative agents of backaches only when some other influence is brought to bear. Confusion often arises because of placing too much dependence on the X-ray picture of a back, for anomalies are common in the sacro iliac and lumbosacral regions.

Sacralization of the fifth lumbar transverse processes is not infrequent, and it causes symptoms (1) when it is involved in a pathological process; (2) when associated with bursæ; (3) when forced into contact with the sacrum or ilium; and (4) when occupation or habit induces a static condition. The tenderness is distinctly localized over the point involved and pain is persistent in certain positions and absent in others. The patient's body lists to the opposite side to relieve pressure, and pain is often felt in the distribution of the fifth lumbar and fourth sacral nerves due to their being pinched or irritated. Osteoarthritic changes may supervene involving the bursa between the sacrum and the long process and in the lumbosacral joint which would aggravate the pain. To truly show the condition by X-ray, stereoscopic plates should be taken, as flat plates are confusing in that they may show impingement when it really does not exist. When the condition is bilateral, symptoms are rare. Removal of the offending transverse process offers thirty per cent. cures and sixty-five per cent. improvement. The rest are unimproved or worse. Wedge shaped vertebrae in the lumbar region is often a cause of scoliosis here. Pain is common, due to stretching of nerves and muscles. Braces are our only treatment. Absence of parts of the sacrum causes an easily recognized deformity, and lumbar ribs are occasionally met and diagnosed by X-ray. If too painful their removal is indicated. Occult spina bifida, which is common, may be symptomless until some traumatic influence supervenes, then a constant ache locally with pain referred to both legs, due to pull on the nerve roots by adhesions, is present. It is recognized by X-ray alone usually and operative closure of the defect is often effective.

(2) Of abdominal causes malpositions

of the uterus and prostatitis or seminal vesiculitis, lead in the respective sexes. These act through referred pain, but the true cause is unknown. Some claim that the low central backache, so intense in character, aggravated by exercise and menstruation, met with in women, is the result of sympathetic pressure peritoneal irritation, broad ligament venous stasis or drag on the infundibulo-pelvic ligaments. Surely we know that gynecological backache, so called, is rarely above the interspinous line posteriorly, and it is central in displacements and acentric and radiating down the thigh in neoplasms. Gynecological conditions as a sole cause of backache are exaggerated, for in the presence of perineal tears, malpositions and pelvic inflammatory disease, static causes often coexist and gynecologists know well that a laparotomy alone will not cure all backache even with possible causes present in the pelvis unless attention be paid to building up the general health and correcting the general muscle tone.

Prostatic or seminal vesical disease causes backache through referred pain in the lumbosacral spine and also by means of metastatic infection causes a local fibrositis or arthritis. The backache is made worse by pressure on the structures at fault, but back motions are not limited. One of the earliest sign of carcinoma of the prostatic is low backache associated with sciatic nerve pain, but with no nerve tenderness. Back support is of no avail in backache of this origin, but the backache is aggravated by motion and the continuous upright position. Uretero- or nephro-lithiasis causes backache, but along with pyelonephritis, pyelitis and cystitis, these can be ruled out by a careful history and urological examination and the two former by X-ray as well. The latter three with perinephritic abscess may interfere with spine motions and may be the source of metastatic infection in the back.

Acute and chronic appendicitis, constipation and rectal diseases cause backache through referred pain and toxic by-products. Carcinoma of the rectum causes a low sacral burning pain. Careful examination should readily expose any of these factors. A hernia, especially one with adhesions, can cause pain referred to the back. In any of these referred pains from the abdomen even though tenderness is present, rigidity is absent and both pain and tenderness are out of proportion to the limitation of motion in the back.

(3) Backaches the result of trauma

often show other conditions which have been aggravated by the injury and which have been symptomless until some external violence is brought to bear. Acute sprains, fractures and dislocations are the most frequent injuries, and a postoperative backache due to lack of support to the lumbar spine during anesthesia is often seen. Acute muscle and ligamentous sprains occurring when the muscles are "caught off their guard," as it were, are common, but one should be certain that this mechanism has not aggravated a previously existing symptomless condition. Flexor muscles are rarely injured while the extensors are the common ones injured, and of these, the largest, the erector spinae, suffers oftenest, the seat of the injury being at the musculo-tendinous junction. The severity of the injury, though, is no index as to the severity of the muscle lesion, whereas in bone and joint injuries pain and limited motion is in direct ratio to the severity of the lesion. Due to its flexibility, the lumbar region is most often affected in this type of injury, and on examination after trauma the curve here is found to be flattened out. Ruptured muscle pain is made worse by stretching and by contraction. It is lessened by rest. Limitation of motion in the lumbar region can best be elicited by lateral bending and hyperextension.

It is difficult to differentiate muscle from ligamentous injury, but in the latter active and passive motions are both painful, while in the former passive motion toward the affected side is painless due to relaxation of the involved muscle. The treatment is the same in both types except that ligamentous injury requires a longer period of rest and support. Recumbency, later adhesive support followed by heat and massage of the back muscles, will give relief. Injured ligaments due to the increased blood supply becomes less elastic, and are thus frequently the seat of secondary toxic deposits and thus become inelastic, and a rigid spine results. I feel that sacro-iliac sprain and lumbago as diagnoses are a sign of an incomplete examination. While a sacro-iliac sprain can occur acutely, still every traumatic backache is not sacro-iliac disease. The joint, like the lumbo sacral, is entirely dependent upon ligaments and muscle tone for support, but is aided in its normal function of weight bearing by its keystone shape. The lumbo-sacral joint, due to our upright positions, has a downward and forward inclination of 30° to 40° and is often the seat of forward subluxation as can be

demonstrated in a lateral X-ray, but only very rarely can any true change be seen in the sacro-iliac joint. However, with localized pain over the joint coming on suddenly following an injury aggravated by flexion of the thighs and pressure together of the iliac crests, with the body weight thrown to the opposite side and pain on flexion of the body, and on deviation toward the affected side, with tenderness over the joint and free extension of the spine, one can conclude nothing but a derangement of this joint as the diagnosis. The X-ray is negative, and when there is sciatic pain it is due to congestion incident to the sprain and not to pressure. I doubt if displacement of this joint occur which can be replaced manually accompanied by an audible click and immediate magic relief from symptoms.

Lumbo-sacral dislocations occur following a fall on the buttocks or a heavy lift. This joint is a pivotal one and is often congenitally weak, and when sprains or subluxations occur there is swelling, as in the knee, accompanied by definite nerve cord or root symptoms due to pressure on the lumbo sacral cord by this swelling. The lateral muscles go into spasm in an effort to fix the joint. If partial sacralization is present in the fifth lumbar it adds to the seriousness of the injury. As is the case in any severe joint sprain, all intercurrent infections should be cleared up, for trauma renders any joint a likely place for metastatic arthritis.

Fractures in the lumbar region occur, and without an X-ray study they may be overlooked. Direct violence, as a rule, causes transverse process fractures, and active motion is limited in all directions with pain and tenderness localized over the injured part. The diagnosis depends on the X-ray, and treatment is by a body cast, which is the sheet anchor in the treatment of all back injuries. If fixed, these fractures heal as well as any elsewhere in the body, but if not, non-union and a chronic backache persist. Sprain fractures occur by indirect violence as a rule. The symptoms are the same, and treatment is again by absolute fixation, for excess callus may form with a chronically lame back.

Crush fractures of the vertebral bodies occur as a result of acute hyperflexion of the spine, and the lumbar region, since it is more flexible than the rest of the spine, is the common seat of these injuries. A lateral X-ray picture is a necessity, and one finds one or more wedge shaped bodies.

This condition is often overlooked until progressive softening of the bodies with its resultant kyphos has appeared, even though backache is constant when ambulatory. There is also pain along the distribution of the spinal roots emerging between the injured vertebrae which is not relieved until hyperextension and fixation have been instituted. Coccygodynia is a burning pain in the sacrococcygeal region, and when localized some trauma is the cause. When, however, this pain is only one of many vague aches and pains, the neurasthenic element enters into the case. For complete cure in the former type coccygectomy is indicated, but beware of it in the neurasthenic type.

(4) Metastatic conditions in the back may involve the soft parts, nerves, bones and joints, and these include all toxic, infections and neoplastic causes, constitutional and metabolic diseases and diseases of the nervous system. Infections involve the bones and joints most frequently, while toxins affect the nerves, muscles and ligaments. Backache is often a premonitory sign of an acute infectious disease, and it is a burning, aching pain not relieved by postural changes. When muscles are involved the changes are usually confined to the sheaths which are the seat of inflammatory changes evidenced by hard tender seed like masses of varying size palpable under the size. This is a fibrositis, and this condition alone should be called myalgia or lumbago. One such attack anywhere in the body predisposes to another. Asthenic and hereditary adipose individuals are prone to this disease which is frequently excited by moderate effort and exposure. The mouth is often the source of this condition and should be cleaned up. The poisons of lead, alcohol and tobacco are often at fault, as are waste products formed in muscle itself from altered metabolism, as in diabetes. The most frequent sites for this fibrositis are in the lumbo-iliac angles, the upper portion of the glutei and the outer edge of the erector spinae in the upper lumbar region.

Peripheral nerves and their sheaths and the spinal meninges are also subject to deposition of toxic and infectious products and all can cause backache, the type being dependent on the structure involved. Meningitis, hemorrhage into the cord, and caudal neuritis, give root pain. Poliomyelitis gives hyperaesthesia with pain and atrophy. Tumors show motor disturbances with pain. Sclerosis of posterior ganglion vessels cause neuralgic and anginal pains.

Peripheral neuritis and neuroradiculitis cause nerve or root pain with atrophy. These are not dull aches as a rule, but severe lancinating pain and can be differentiated if attention be paid to the reflexes, sensation, trophic changes, motion and distribution of pain.

Hysteria and neurasthenia (traumatic neuroses) give variable and inconstant findings in backache and are always accompanied by a disturbance of mental equilibrium and pains elsewhere. All structural causes of backache should be ruled out, for often a traumatic neurosis, so called; has such an etiology. Syphilis, especially syphilitic meningitis, causes intense backache. Endocrine imbalance is said to cause backache at times, but I believe all such sacro-iliac arthritis are always accompanied cases are static in origin. Spondylitis and by backache, which may be greatly aggravated by injury, postural conditions and stress of every-day life. Truly traumatic arthritides do occur, but are rare, and nearly always they are the result of infection elsewhere in the body. Gonorrhoeal arthritis is very prone to be localized by trauma. These infections may be acute and frank, or chronic and insidious, local or general.

The back involvement manifests itself by local pain extending into the buttocks or thighs with stiffness and recurring acute attacks of so-called "lumbago" following trivial causes. The lumbar physiological curve is lost, and the spine there is flat with a marked dorsal posterior convexity with the head forward. The X-ray early shows marginal lipping of the bodies. The discs slowly disappear, and when advanced the bodies are in contact. The spine becomes rigid due to muscle spasm and inelasticity of the ligaments. True bony ankylosis rarely exists. Sciatic pain often accompanies this condition, but it is referred or else of perineuritic origin. To be a true neuritis it must show muscle weakness and atrophy with the pain, and these are rarely present. The disease is often limited to the lumbo-sacral region of the spine. When complete ankylosis supervenes, the pain ceases, but stiffness and clumsiness in movements persist. The infectious focus must be eliminated to stop the process. Even though a given case might have a positive Wassermann, the patient must improve on antiluetic treatment, otherwise some other focus must be sought and eliminated.

Tuberculosis of the spine or sacro-iliac joints to be discovered early necessitates a thorough examination. Early in these dis-

eases the pain is referred to the peripheral nerve distribution. Later it is localized in the involved area. Later the swelling and kyphos, plus positive X-ray findings, make the diagnosis easy. Pyogenic osteomyelitis is rare, but when present is very acute and shows all the signs of the disease as seen in long bones. The pain is constant whether at rest or active. Syphilitic osteomyelitis is much more chronic and the pain is nocturnal. Bony neoplasms of primary origin are rather rare in the back, although secondary growths in the spine are frequent, especially from the prostate in men and the breast and uterus in women. The pain is persistent and excruciating, and often radiates to both sciatic regions. This bilateral sciatic pain is rare in traumatic and static backaches. The X-ray shows the typical moth-eaten bony shadow.

(5) By static backache is meant that which is non-infectious or not secondary to derangements of special organs or intercurrent disease and injury. These backaches owe their origin to persistence in unnatural positions sufficiently long to have become habit forming. There are four normal back curves, three of which are flexible and one bony: (1) Cervical, 1st cervical to 2nd dorsal vertebrae, which is concave backward; (2) Dorsal, 3rd to 10th dorsal vertebrae, convex backward; (3) Lumbar, 11th dorsal vertebrae to the lumbosacral joint, concave backward; and (4) Sacrococcygeal, convex backward is fixed and immobile. The first three are the result of the upright position of the body and are maintained by muscular effort and ligamentous support. These allow the spine its mobility, and when one curve is increased the others must increase to maintain the normal center of gravity which is in a line from the tip of the mastoid, through the front of the shoulder and great trochanter, just back of the patella to a point one inch in front of the external maleolus. Thus the center of gravity is in front of the center of support of the back, the lumbosacral joint, and the posterior back muscles therefore are stronger so as to carry the anteriorly placed load. Abnormal postures are the result of muscular weakness, and so a vicious circle is established of weakness causing strain, and strain causing weakness. Often backache of pelvic organ can be traced to the patient's efforts to assume a comfortable though unnatural position.

These postural defects may cause no trouble for years, when, because of a depreciation in vigor from some cause symp-

oms begin. They may mean much or little, depending on the maintenance of physiological muscle balance. Static backaches are evidenced by a dragging, irritable pain in the lower spine or sacro-iliac joints, with obvious defects in balance, with a negative X-ray and neurological examination. Two types of patients are frequent sufferers: (1) The heavy set broadback patient, and (2) the one with congenital visceroptosis. In the latter all motions are too free, and in the former too limited.

In the diagnosis one must consider whether the condition is acute or chronic, periodical or constant, the effect of movement, the presence of tender pressure points, and the general posture, gait and balance. The stripped patient should be examined standing, prone and supine, with special attention to the feet and legs for assymetry. Weak or flat feet are almost always associated with a weak back, and both must be corrected to relieve backache. During the late war twenty-five per cent. of those with poor posture had backache, and the rest were never efficient. The so-called military position with head up, chest high, chin pulled back, abdomen held in and the lower back flattened, gives relief from postural backache. This position can be attained by exercises, voluntary effort, and often by a back brace with an abdominal support. Anteroposterior deflection of the body is the most common postural change. Any increase in the anterior load of the posterior back muscles causes backache such as a pendulous abdomen with sway back, and the slouch with round shoulders and protruding abdomen so common in young girls. Flat feet because of a rotation of the necks of the femora and shortened tendo achilles with the feet flat on the ground, with the necessary hyperextension of the knees both cause tilting of the pelvis and secondary increase in the normal spinal curves with lumbo-sacral backache.

Lateral spinal deflection in addition to backache often causes radiation of the pain to the legs. The pain is on the convex side of the curve unless due to pressure of the ribs when it is on the concave side. These conditions may be primary back curves due to early rickets, infantile paralysis, defective vision or habit, or may be secondary to a congenital or acquired deformity in the leg, upsetting muscle and bony balance. A condition often overlooked is that the legs may vary in length $\frac{1}{4}$ inch to $\frac{3}{4}$ inch and still be within normal limits. Static backache in women, persistently aggravated

by menses, makes one suspect a pelvic cause as well as poor posture.

The outlook in these cases is good if uncomplicated by a neurosis, but it is slow if muscle tone is poor. Correction of the underlying cause, plus assumption of proper posture and the wearing of a corset support, are of importance. Corrective exercise and proper rest, early, and later baking and massage, give symptomatic relief. If adhesions are present but no arthritis, these should be broken up, followed by active exercise.

DISCUSSION.

Dr. Thomas B. Lee, Camden: Dr. Buzby said very properly that backaches due to gynecological causes had been very much exaggerated. Of course, that is not so true now as it was a few years ago when all backaches which women suffered in the lower parts of the back were ascribed to some gynecological disturbance, but better neurology and better internal medicine and better orthopedics have limited the number of backaches which we can actually ascribe to gynecological disturbances. However, there are a few very definite causes to be found in the female pelvis for backache, which, as Dr. Buzby said, is always found down in the spine. Perhaps the most common cause is the so-called chronic adhesive pelvic peritonitis, which results from an acute attack (of greater or less severity) of peritonitis, which may be so slight as to almost escape the memory of the patient having had it or may be so severe as to keep the patient in bed for many weeks at a time. This is even sometimes mildly progressive and causes an intense backache which is only relieved by relieving those organs in the pelvis which are bound down by the resulting adhesion. Another, and I think commonly overlooked pelvic cause of backache is that due to chronic inflammation of the cervix, which results, after a time, in a chronic inflammation of the uterus or a chronic nephritis. The pathologist tell us that this is a lymphangitis of the uterus. This is easy to discover from the appearance of the cervix and the fact that the cervix is unusually sensitive to the examining finger and is usually slightly enlarged. As Dr. Baldwin pointed out many years ago, the only way to relieve backache from such a cause is to completely remove the uterus, and the results in these cases are very good.

Malignant diseases of the pelvis at times causes backaches late in its course, but this is usually unilateral and its distribution corresponds to the nerve trunks that are involved in a malignant process. Another form of backache of partly gynecological origin, or the type of backache which frequently presents itself to the gynecologist, is that type associated with overweight, amenorrhea or oligomenorrhea, oftentimes sterility, and sometimes dysmenorrhea. This is distinctly endocrine in its origin, probably hypofunction of the thyroid and the ovary. But these people often complain only of intense backache. The successful treatment of these cases depends absolutely upon reducing their weight. If the patient will diet, with the assistance of some

organotherapy, and the weight becomes reduced, as Dr. Buzby has said, these cases are static; that is, they come under the static class of backaches, the greater part of the body weight is in front of the center of gravity, which the doctor has pointed out to us. One patient just recently that I have known about has had a backache for several years, but her backache instantly disappeared when she lost twenty-five pounds. (Applause)

Dr. Robert E. Soule, Newark: Mr. President, I think this is an extremely important topic and I don't know when I have listened to a paper on this subject that has interested me more and has contained so much meat in the context. I think this is an admirable paper and I believe every one of us will take this paper and read it carefully and a little more slowly than the doctor gave it to us, we will get a great deal more out of it, when it is published. There are a number of points in this paper that every general practitioner can take home with him and go over a series of his patients that have backaches, after perusing the paper, and it will help him amazingly in elucidating the problem. There are two things that occur to me in relation to this. Last Monday I had a young lady come into my office, of about fourteen, who had a slight curvature of the spine—perfectly flexible; gave the history of trauma about six years earlier, and the fact that she had a half inch shortening in one leg had been entirely overlooked in the previous examination. That was enough to account for the asymmetry of her spine and the tilting of the pelvis, and the cause of the pain, which was easily corrected, as the doctor has mentioned, by elevating the short leg heel.

Now the point of sciatica. I think the profession is coming to realize that sciatica is a mere symptom in a maximum of cases and should be looked at as a symptom, not as the general term rheumatism, which covers a multitude of sins; but we ought to go into the diagnosis of sciatica and get something more pointed than the mere term sciatica. It is only a symptom and, as the doctor has shown on the screen there, bone change in the fifth lumbar vertebra is in very large measure a source of a sciatic condition; and I have relieved many of them by either removing the impingement of the lateral masses on the segment and raising the segment that much higher.

COMPUTATION OF THE PERCENTAGE OF PERMANENT DISABILITY IN EYE INJURIES, UNDER THE EMPLOYERS' LIABILITY ACT*

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Since 1910 the principle of the liability of the employer for personal injury caused to an employee, by accident arising out of or

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in the course of his employment, has been recognized in this country. In the meantime, 45 of the 48 States have adopted an employers' liability act. New Jersey fell in line early, the original act having been approved April 4, 1911. The law has been amended and supplemented from year to year, and although still far from ideal has been of great benefit to both employes, employer and the public at large.

The intent of the law is to provide prompt and average industrial compensation for accidents, without placing a premium on injuries. The machinery provided for its administration is simple and efficient, and saves much expensive litigation. Under the old laws governing employer and employe, the employer was not liable for injuries unless negligence on his part could be shown, and the burden of proof was on the employe. Injuries due to carelessness of the workman or of a fellow employe had no standing in court. Under the present act, practically all injuries causing temporary or permanent disability, no matter to whose fault they are due, are compensable. The only exceptions are self inflicted injuries and those due to intoxication, and in these cases the burden of proof is on the employer.

Among the many good results of the law, the greatest is the very notable reduction in the number of industrial casualties. This has been brought about largely through the increased use of safety appliances in manufacturing plants, and by "safety first" propaganda. Commenting on this phase of the subject in the North American Review (May, 1923) Gorton James says, "The number of accidents and their gross cost to society have been reduced beyond the wildest dreams of the original authors of accidents compensation laws"..... "Manufacturers making safety devices and guards, who could not sell their wares before 1910, found themselves the proprietors of thriving businesses after the compensation laws were passed. It paid the employer to prevent his employes from being careless. Before the enactment of those laws it was 'none of his business' if the workers did not want to be careful, but now it was money in his pocket if he could educate his force to careful habits."

The principal purpose of this paper is to call attention to the need for greater uniformity in our methods of estimating the percentage of industrial disability caused by injury of the eye or its appendages. In this state and elsewhere there is considerable lack of uniformity, although much has re-

cently been done in some States or communities to co-ordinate the views of ophthalmologists on this subject. Workmen's compensation laws are made and administered largely by laymen, but they depend on the medical profession for an estimate of the amount of disability caused by each individual injury.

In the case of some injuries, particularly those of the extremities, the law definitely fixes the award according to the extent of the anatomical loss. Thus, two-thirds of the daily wages for 60 weeks is awarded for the loss of a thumb. A certain rating is given each finger or toe or portion thereof; four weeks for each tooth lost, etc. Other injuries, not involving anatomical loss, such as impaired mobility of the joints, are not so easily rated.* Likewise when we come to the eye and there is anatomical loss, that is if the eye is destroyed, we have the schedule to guide us. The law says, "For the loss of an eye, sixty-six and two-thirds per centum of daily wages during one hundred weeks.

It is in the cases of less than total loss of the eye (or sight) that the ophthalmologist is called on for an opinion as to the percentage of loss. This is not always an easy matter to determine. The law says, "In all lesser or other cases involving permanent loss, or where the usefulness of a member or any physical function is permanently impaired, the compensation shall be sixty-six and two-thirds per centum of daily wages, and the duration of compensation shall bear such relation to the specific periods of time stated in the above schedule, as the disabilities bear to those produced by the injuries named in the schedule." We are not asked to go into the visual economics of the case. The law fixes the compensation arbitrarily. It does not consider the nature of the workmen's occupation, or the relation of his disability to his future earning capacity, or his ability to compete. Our opinion is concerned solely with the *percentage of disability* suffered by the injured organ, and the compensation is the same whether the workman is a laborer requiring comparatively little vision, or a highly skilled artisan whose calling demands good vision. On the whole, it is well that this is so. The law endeavors to provide a practical, workable method of granting average industrial justice. To attempt to estimate the per-

* For this class of injuries Dr. William Goodwin of Newark has devised an ingenious and valuable method of estimating the disability.

centage of disability according to the laws of visual economics would greatly complicate what is often already a difficult problem.

It often happens that when two or more ophthalmologists are asked to make an estimate of the amount of disability in a given case, there is a wide divergence in their conclusions. The compensation courts seek, and are guided by, our opinions, but what must they think and what can they do when one expert in a case reports 10 per cent. loss of vision and another 50 percent?

There are several reasons for this. One of our chief difficulties, or I might say errors, has been the quite common custom of making the ability to read standard test type such as Snellen's at a standard distance, or in other words, central visual acuity, the sole basis for estimating the impairment of visual function. The fractions 20/30, 20/40, etc., have been used as equivalent to thirty-three and one-third and fifty per cent. loss of visual efficiency. In doing this we have overlooked the fact that normal physiologic vision consists of several factors, three of which are essential, viz.: Central visual acuity, visual field and binocular single vision. The fractions 20/20, 20/30, 20/40, etc., have been erroneously used as percentages of visual efficiency. They were never intended to be so interpreted. A person may have normal visual acuity in each eye and on account of paralysis of an external ocular muscle, causing diplopia, be practically monocular. Or another with good central vision may have so much contraction of the visual fields as to unfit him for many occupations. On the other hand there may be considerable reduction of visual acuity from a small central macula of the cornea, without causing much or any inconvenience if the other factors of visual function are normal. In fact many people whose vision in either eye is no better than 20/30 or 20/40, go through life pursuing occupations requiring close work of the eyes, unaware that their vision is impaired. Therefore if the vision in a given case is 20/30 or 20/40 or 20/50, without other disturbance, it is not correct to say that the eye is damaged to the extent of thirty-three and

one third per cent., fifty per cent. or sixty per cent.

It is pretty generally accepted that for the purpose of estimating industrial visual disability, 20/20 is standard vision and 20/200 or thereabout is industrial blindness.* The difficulty has been in coming to an agreement as to the proper valuation as expressed in percentages of total impairment, of the various intermediate fractions between 20/20 and 20/200. If 180 feet, the difference between standard vision and industrial blindness represents 100 per cent., it is clear that 20/30, 20/40 or 20/50, or a difference of 10, 20 or 30 feet respectively, cannot be equivalent to thirty-three and one third per cent., fifty per cent or sixty per cent. This can be shown graphically by drawing two radii of a segment of a circle subtending an angle of five minutes, (the principle on which the Snellen letters are made,) each radius representing 200 feet, and inscribing a Snellen E at various distances in the angle thus formed. The 200 foot letter is ten times as high as the 20 foot letter and five times as high as the 40 foot letter, and has a proportionate value to the other letters. * * *

These facts have been officially recognized in some states. Attempts have been made to construct tables representing in percentages of visual efficiency, the loss as shown by the ability to read standard test type. These are necessarily somewhat arbitrary, and are made with the fact in mind that many cases have unusual features which must be considered individually. Three or four years ago the Chicago Ophthalmological Society considered this whole subject very carefully, and adopted a table very similar to the following. It seemed to me to be the fairest that had been proposed and since its publication in May, 1920, I have used it, with modifications for unusual cases, with satisfaction.:

* Several states, by legislative enactment or judicial interpretation, have made 20/200 vision industrial blindness. An exception is New York State, where 20/100 is, legally, industrial blindness. In this state the compensation act fixes no standard, but by custom and usage 20/200 has been accepted and this has not been contested in the courts.

**



| Vision | Percentage of loss |
|--------|--------------------|
| 20/20 | 0. |
| 20/30 | 5.5 |
| 20/40 | 11. |
| 20/50 | 16.5 |
| 20/60 | 22. |
| 20/70 | 28. |
| 20/80 | 33. |
| 20/100 | 44.4 |
| 20/120 | 56. |
| 20/150 | 72. |
| 20/180 | 89. |
| 20/200 | 100. |

(industrial blindness)

It is based approximately on the equation x (% of loss) is to 100% as the denominator of the Snellen fraction representing the visual acuity in the given case less 20 is to (200-20) or 180.

This method, theoretically, gives no consideration to loss of visual field or binocular single vision, but practically, it does. In the large majority of the cases of impairment of visual function by injury, these two elements of vision are not separable from central visual acuity. The whole matter has been very much confused by impracticable theorizing,

Every one who has had much experience with eye injuries, knows that concentric contraction of the visual field from injury is an extremely rare condition. Less rare but also very infrequent, are cases of loss of sectors or islands of the field, such as those caused by through-and-through injuries by small particles of metal, small detachments of the retina, etc. Very unusual, too, are cases of loss of binocular single vision, without coincident loss or considerable impairment of visual acuity. Occasionally this occurs, and is caused by injury of an external ocular muscle or its motor nerve or of the orbital wall. But in all cases in which there is large reduction of central visual acuity there is necessarily a loss, or at least great dimness, of a more or less large area in the center of the field and a loss of binocular single vision or its important element, stereoscopic vision.

Now as applied in practice the above table is fairly just and equable, because, in the cases of small or moderate impairment of vision in which there is usually no appreciable loss of field, and binocular single vision is present, or in other words, where the industrial depreciation of vision is slight, the increase in the percentage of loss reckoned on a footage basis is relatively small. But in the cases of greater loss of central vision, with its accompanying im-

pairment of the other two factors, on account of the gradations in size of the larger Snellen letters as commonly used being greater, the intervals after 20/70 being 30 to 50 feet instead of 10 feet as with the smaller letters, the percentage increases much more rapidly. In the large majority of cases this method can be satisfactorily used. In certain types of ocular injury the percentage of disability cannot be computed by any table or rule. Such conditions as ptosis, lagophthalmos, paralysis of the iris or of accommodation, entropion, epiphoria, metamorphopsia, blind areas in the field of vision, disfigurement, etc., require special consideration and usually additional compensation.

In 1921, the Eye, Ear, Nose and Throat Section of the Academy of Medicine of Northern New Jersey appointed a committee to report on an acceptable method of computing the percentage of disability caused by eye injuries. The committee consisted of Drs. Wallace Pyle, Lawrence Dias and the writer. That presented here is the method recommended by the committee and adopted by the Section. It has been found to be simple and practical, and there has been much less discordance than formerly in the opinions of ophthalmologists reporting on a given case.

The committee carefully considered the report of the Committee on Estimating Compensation for Eye Injuries, of the Ophthalmological Section of the American Medical Association. While the report contains many admirable features, it is in some respects impracticable and unfair to the injured workman. It conflicts with certain legal limitations in this and various other states, and has received considerable adverse criticism. Time does not permit extended comment on the report in this paper. The committee that made the report unreconcilably disagreed among themselves, and both a majority and minority report were presented at the 1922 meeting of the A. M. A. The majority report was approved but apparently has not been finally adopted, as the Committee was continued.

Divergent opinions as to the percentage of disability caused by an injury may often be brought into accord by the surgeon interested in the case getting together in a spirit of accommodation, and discussing the points of disagreement. This may make attendance at the Compensation Court unnecessary; or if testimony is taken it obviates the spectacle of Dr. X. testifying that two times two are five, while Dr. Y. swears that the correct product is six.

The compensation courts always want our opinions expressed in percentages of visual disability. The former custom which, to some extent, still continues, of using Snellen fractions in making reports and opinions which are to be read by a layman, is confusing and always leads to questions concerning interpretation of the terms used. In the phraseology of the law, percentage is used constantly. Snellen fractions are nowhere mentioned.

Concerning the use of glasses to improve vision impaired by injury, the New Jersey Supreme Court has recently decided (*Johannsen vs. Union Iron Works*) that the improvement obtained by the use of glasses, of vision damaged by injury, cannot be taken into consideration in estimating the percentage of disability. This apparently would not apply to any impairment that existed before, but only to the increase caused by the injury. As a matter of fact, impairment of vision caused by injury is usually of such a nature that it cannot be improved by glasses. The most common exception is traumatic cataract. Under this ruling all such cases must be awarded practically 100 per cent., even though 20/20 vision be obtained after removal by operation or absorption of the cataract.

In some cases the difficulties of making a fair and accurate estimate of the impairment of vision are very great, especially with dishonest claimants who want to capitalize the injury. This is particularly true of foreigners whose native language is unfamiliar to the examiner, and whose only knowledge of English is "Me no can see." In such a case, in which for example, there has been a trifling superficial injury of the eye where there is little or no scar or other sign of damage, considerable astuteness and even subterfuge on the part of the examiner are required to demonstrate that the eye has good vision.

All employers engaged in manufacturing should have a simple visual test made of all new employees, and a record kept of the vision. It often happens that an eye that is already more or less defective is injured, causing still further impairment of vision. In such a case, without some record of the vision before the injury, it is often impossible to separate the impairment caused by the injury from that pre-existing, and the examiner can only use his best judgment.

In all cases of injury coming for treatment, it is worth while to test the vision at once or as early as possible and get the individual on record, so to speak, before he has time to think of, or have suggested to

him the possibility of making a "good thing" out of his injury. In case of reasonable doubt the decision should favor the workman.

DISCUSSION

Dr. Charles H. Schlichter, Elizabeth: Mr. President and gentlemen—I think Dr. Sherman is to be commended for bringing this subject to the attention of this Society, because from that will result the publication of the paper and it will be distributed among the ophthalmologists of the State. Prior to the publication of the table of the Chicago Ophthalmological Society, we in Elizabeth were often confronted with this same problem: How much shall we allow this injured man for loss of vision? Based on the Snellen types, in the way formerly used, a great many of the awards seemed excessively high and did not seem to do justice to the employer and to the insurance carrier, though always bearing in mind that the injured man should have the benefit of all doubts. Since using this table in our district, we have had very little trouble. The Deputy Commissioner who presides there, Mr. Boyd, has practically accepted it and at least based his awards on the figures that we have submitted. It is not perhaps a perfect thing, but I believe, judging from my own experience, it is the best that we have had thus far, and it certainly represents an advance in compensation for eye injuries. Dr. Sherman spoke of getting together. There is no question about that. We should get together more before going into court, or before appearing before a commission. I have always felt very strongly about that and have always used every effort and therefore have appeared in court but little. I find that if you go to the other fellow and discuss the matter with him in an open-minded way, usually it is possible to get together and the patient or the injured individual gets a fair verdict.

I want to emphasize a few points which the doctor made that I think we should carry back to the industrial concerns for whom we do this kind of work. The first is that every employee's sight should be examined by a competently trained individual—not necessarily a doctor, but an intelligent man who can do that work. I have had a number of cases recently in which that has helped out the employer very considerably. We would have had to stand for a big verdict had we not been able to show these records and show that this man had poor vision in that eye before he took employment where the injury occurred.

Another important point the doctor made was to take the vision just as soon after the injury as it is possible to get it. Of course, we all know that in some cases it is useless to do that with certain types of injuries, but in others, before the patient has had much time to think it over and to magnify that injury, if you get his vision then, I think you will be able to arrive at a fairer basis of award.

Altogether I think this is a most timely paper and one which should be given wide publicity, with a view of bringing us together in this perplexing subject, so that the profession will not appear before the public as always being opposed one to the other.

Dr. Edgar Holden, Newark: I am much pleased that Dr. Sherman has taken this opportunity of trying to get a uniform schedule. I wish we could be uniform in all these things. In the work in connection with the compensation court estimating, we are up against the sad spectacle all the time of one doctor getting up and swearing one thing and another one getting up and swearing another which is absolutely opposite, and it really is most distressing; it creates a bad impression on the judge; it creates a bad impression on all the spectators, and the petitioner, and every one concerned. In a recent case, a man came in, claiming an injury and a very great loss of vision. He had letters himself from two ophthalmologists, saying that this great loss of vision was absolutely due to the accident. He also had a letter from a doctor (not a ophthalmologist) who said that in the course of his employment he had examined the man's eyes and if the man had had bad eyes, he would not have passed him. On the other hand, the insurance company had letters from two doctors who swore to the fact that the man did not have bad vision. One of those was one of my consultants. During these informal hearings, I sit up in front with the judge and go over these cases with him. I said to the judge on this occasion that even though I had made up my mind from the letters, after having read them, I wanted to send the man in question to another man, I wanted to send him to Dr. Sherman for another examination. I felt it was due the man to have an unbiased examination by a state physician. So I sent him to Dr. Sherman with the distinct understanding that when that letter came back, the judge was going to abide by the decision. Dr. Sherman sent back a letter, just as I expected he would, stating that the accident had not caused the disability.

The necessity there comes in, of having several consultants, because if a man comes in and the company has had him examined by Dr. Sherman—not that I doubt Dr. Sherman's word, but I feel that man is entitled to an examination on his own hook, that is by the State; so I send him to Dr. Quinby or one of the other consultants for an absolutely unbiased opinion. The man then is absolutely satisfied; he doesn't have any complaint coming. Of course, the whole intent of the Compensation Law is to provide adequate compensation without any need of a lawyer and without any expense to the man. (Of course, at a great many of the hearings the man appears with a lawyer, and that is unfortunate because he is paying for something he does not need; he does not need a lawyer with him to protect his rights) and also to protect the employer against fraud. The doctor did not bring out the question of liability for the aggravation of a pre-existing disease. The law all over the country, not only in the compensation courts but in the general courts, provides that if there is a disease which is aggravated or intensified or lighted up by a injury, that is compensable. In the case of latent syphilitic lesion, if that was latent beforehand, and after the accident it became aggravated and the loss of one eye ensued or the loss of both eyes ensued, that is compensable under the law.

There was another question the doctor brought out about a fracture of the skull, with a consequent eye disability. There I believe, even if the eye is only damaged to the extent of only 15 per cent., the man is entitled to have compensation for that fracture because I do not believe that a man with a fractured skull is ever as good as he was before. I think he is entitled to have some compensation and the amount of it is dependent upon the amount of disability which he has afterwards. In those cases we try to provide for a further examination. I send them to Dr. Bissett for a thorough examination, so that they can be put through the various tests to see if they show any symptoms referable to that fracture. It is very difficult, all over the body, to estimate in per cents, there is no doubt about that, and it is impossible to get up tables. I have thought and thought of some way to get tables so that we could get together on this, but the only way we can do it is to try and work out, as Dr. Sherman has done here, one table which we can follow somewhat closely, and in the same way as the doctor brought out about the measurements of disabilities of joints, and so on, to measure them with an arthrometer, particularly the one that Dr. Goodwin has perfected; it is a very nice, handy one for carrying. But even there we are up against this: The joints may move a certain percentage, and the joint may be deformed in addition, it may be swollen, there may be a further disability or a lack of alignment; so that has to be taken into account.

On the question of hearing (this is a little aside) in hearing we have to estimate, I believe, not only the acuity of hearing for the near objects, but we also have to take into account the distant hearing and the tuning-fork. To estimate a man's hearing by the use of the tuning-fork would be valueless from the standpoint of the man because his hearing that is valuable to him is really the distant hearing. So that I think it ought to be divided up, say, one-quarter for the tuning-fork, two-quarters for the distant hearing, and one-quarter for the near, as was brought out in a recent paper. On the question of occupation entering in, of course it is just in one way. In this State we cannot take into account the man's occupation. If a man has an eye injury, and he is a diamond setter, he is awarded just the same, under the law, as a laborer. A laborer might have a 60 per cent. disability of one eye and yet be able to work well, and the diamond setter by a disability of 60 per cent. is almost put out of business. New York State provides for that, but we do not; so that has to be left out of account. The court ruling in all cases is bound to be on the medical testimony; the lay judges do not estimate, they do not want to do it, and in all the courts, except the informal hearings, the judge collaborates there. After the informal hearings decision in a court is based on a preponderance of evidence.

In one case of a formal hearing, the judge said he was very much distressed. The man had had a blow on the head; his head caved in, and they performed a decompression. The company appeared with letters to claim they had had no disability. They presented the doctor's argument that he had had no disability.

ity from that decompression operation and fracture. The judge argued; He said he felt in his heart there was a disability but he could not prove it. He could not call in medical testimony. The only medical testimony that could be presented was by one side or the other. He had a talk with me after the trial and said he was perplexed about the case. He said, "Well, wouldn't it be dangerous if this man was hit on the head?" I said, "It would kill him." He said, "There is a disability in this case." I said, "Can't you bring anybody in?" He said, "It is unfortunate but I can't." I think the law should be amended so that the judge might bring in some unbiased testimony, if he wanted to. There is the question of consultation. If we could only get together before going on the stand, so that there would not be that spectacle of widely divergent opinions, it would help wonderfully.

Not long ago there was a case in Elizabeth and there were six men to testify and they estimated on the case before Judge Boyd, their estimates being from 15 to 60 or 80 per cent. They all differed. Judge Boyd got them in a room together and said, "Gentlemen, I want you to get together on this case; I am going to leave you here together to talk it over." He left them for a time and came back again, and they were as far apart as ever. He repeated his request again. He said, "Gentlemen, you don't seem to be able to get together. I have been thinking this over. Would you agree on thirty-three and one-third?" They all agreed and they went in and settled the case on thirty-three and one-third per cent. Judge Boyd got a very nice letter from the Welfare Committee on his Solomon-like judgment. The advantages of a mathematical proposition are numerous. A mathematical computation like that appears to the judge and it appeals to a jury, if there is one, and it appeals to the men. If we can only put all of it on a mathematical basis, it will be a wonderful help. The use of eye glasses is just the same as the use of a pair of crutches or an artificial leg; it does not diminish the disability. Of course, in a reasonable doubt, we ought always to favor the workman. Then there is a question which I would like to close with, and that is the effect on the judge of agreement and of uniformity of testimony. The judges are all greatly impressed with that. If a man uniformly goes on the stand and he is not always differing from somebody else, his testimony will stand right out.

I remember, when I was talking to Judge Osborne one night, up at his house, I found him reading a medical book. I said, "Are you going to study medicine, Judge?" He replied, "No, but I am so disgusted with the medical testimony that is presented, I don't know what to do. I can't believe anybody, and so I have to get medical books and read them up on the case myself in order to know who is telling the truth." The satisfaction that I spoke of is brought out by this: Recently I was very much pleased to be subpoenaed by both sides in a number of cases. I feel, when they do that, they think that I am fair.

Dr. Talbot R. Chambers, Jersey City: Mr. President, Hudson County sometimes says that something comes out of Essex, and I am reminded of Don Marquis, who told about the

couple on their honeymoon. This couple had a fight, and he thought he would have to hit her one. There were some mules, as they were motoring by, standing and braying at them, and he looked at her in a kindly way and said, "Relatives of yours?" She thought a moment and replied, "Yes, by marriage." I have heard this paper of Dr. Sherman's, and I am very grateful to him for bringing it out, for bringing up the subject, and for the elaboration of it, of Dr. Holden. It has been a question that I have felt my own weakness in. I came down to hear this paper, and I am abundantly satisfied that we do not know any more in Hudson County than they do in Essex, and that the problems that are presented to us are the same as those presented to you. There was one point that he brought out, which I think would help very much if it were made a law among the employers to have a record kept of each individual who is hired at the time he is hired, and then when an accident does occur, the previous history is on record.

I wanted to speak about a case that is in the course of settlement and bring out an idea which is new to me. I have not seen it recorded. A man about fifty years of age, a plumber, is the victim. An explosion took place. In the evidence he said: "Was struck on the right eye a year ago." It was allowed that there was a total loss in that eye. He now claims he cannot work because he cannot see with the left eye. Examination shows he has twenty-two hundredths, 20/70, with a plus-one cylinder. The fundus of the eye, unfortunately for the defendant, perhaps, is perfectly normal and nothing can be seen out of the way. But that eye is sluggish. Of course, there is no changing nor pupil division because the man does not see as he should. It does not react to light. I claim that that eye is damaged by the accident. How do you get it? It is not sympathetic ophthalmia—No! It is not sympathetic disease of the left eye, which we generally think of as a disease passing from the diseased eye through the lymphatic system, around to the other eye, an injury particularly of the ciliary body. It goes around through the lymphatic system to the good eye. It is not that. I hold that the shock of the blow upon the right eye damaged the optic fibers going around from one eye to the other. That is not according to Hoyle; I don't think you will find it anywhere, and I don't know whether there is any foundation for it, and I don't know whether there is any sense in it, but that is my opinion in regard to that case, and I should like to have it either knocked down or upheld.

Dr. C. W. Crankshaw, Newark: I enjoyed Dr. Sherman's paper and Dr. Holden's discussion and Dr. Chamber's remarks brought me to my feet. As physician in charge of the Prudential Infirmary, in the group building there we have over five thousand employees, all of whom are examined preliminary; and not only in the clerical part but in the printing part, in the bindery, the engineers, the elevator men, the porters, and the entire group of employees. Those who require a mental test in the clerical division are given that first, and then the physical examination takes place. That physical examination includes an examination of the visoin, and we find some cases where it is

necessary for them to have glasses, and as Dr. Sherman is consulting oculist, we refer those cases to him. In that way we have a complete record of every case that comes into the employ of the company. The remarks of Dr. Holden in regard to litigation prompt me to cite a case of interest that occurred in a distant State. A gentleman was riding on a train and an insane woman, who sat back of him, ripped out a revolver and shot him in the neck. He recovered from the wound, as far as the pistol shot was concerned, but he put in a claim that he had defective vision as a result. It was shown that a previous examination that had been made by a very competent ophthalmologist recorded that this man had a very high blood pressure, nephritis, and hemorrhage of the retina vessels, and adenitis, showing that that was all previous to the injury had nothing to do with the defect of the vision. This case illustrates the great importance of examination previously, with particular reference to the vision.

Dr. Elias J. Marsh, Paterson: I agree with Dr. Chambers that we are all very much indebted to Dr. Sherman for bringing this matter before this Society. Though this might seem of ophthalmic interest only, it is not; it brings to our attention matters in connection with industrial insurance. I want to bring before the Society two matters. One is in reference to what Dr. Sherman said about the trouble you get into if you mention before a man who is not a medical man, be he a lawyer, an insurance agent, a jurymen or anyone else, the Snellen fractures; that you are certain to get a misunderstanding. He gets the idea fixed in his mind and if you try to talk percentages to him afterwards, to explain to him that a Snellen fracture is not necessarily a percentage of physiological vision, it is impossible to convince him. Some tables will help a great deal, but it will help a great deal more if in the courtroom the Snellen fracture is entirely forgotten. The other point I wanted to endorse, of Dr. Sherman's, is that it will help a great deal if the men will consult before they appear before the commission, or the court, or give whatever opinion they have to give beforehand. I am glad to say that in Paterson the different ophthalmologists work in very close harmony and intimacy, with so few exceptions that they hardly count, and I know of a number of cases where consultation of that sort before the case was brought up has helped a great deal.

Now I would move you, Mr. President, that a committee be appointed from this Society, of which Dr. Sherman shall be Chairman, with two ophthalmologists from other parts of the State and two men not ophthalmologists, who are interested in industrial medicine, to be appointed by the chair, to report to this Society next year some scheme (this one possibly or some others may seem best) to be presented with the endorsement of this Society to the Department of Labor and Industrial Compensation, to be accepted as far as possible as a standard to be used in all discussions through the State, because otherwise when you come to bringing up several different systems before the commissioners in different places, they become confused. I offer that motion. The motion was seconded by Dr. Johnson.

Dr. Chambers: This is the Silver Jubilee in

New York; it has been the Silver Jubilee of the Practitioners' Club in Jersey City. It has been the greatest quarter century in the world's history. If this motion goes through and you are able to settle this, it will be only one more milestone in the greatest century in the history of the world. I second that motion and hope the Committee will be able to do something which will make possible justice to both the employer and the employee. We have no right to be influenced by prejudice.

Dr. W. B. Johnson, Paterson: I agree with all the gentlemen, that the doctor is to be congratulated upon having brought this subject before us. It is a very important subject, and it is a subject on which we must get in accord. Our troubles are lack of uniformity of report. The only way you can get uniformity of report is to have everybody, to the best of his ability, report in a straight forward and honest manner, no matter whether he is employed by the employer, employed by the insurance company, or employed by the individual who is injured. This lack of uniformity sometimes results from loss of a desire on the part of the individual to do the right thing—I am speaking about the doctor now. We all know that we think and believe that it is the duty of every man who undertakes the practice of medicine to undertake it honestly, and he ought also to undertake to report honestly.

We could talk about this matter of medical evidence from now till next year and we would still be at sea because the people do not act together. If Dr. Marsh's suggestion results in the appointment of a committee which shall settle on some definite idea of a uniform standard which we can follow, it will be wonderful assistance to us. It may not be absolutely correct, but it will be sufficiently correct for practical purposes and it will impress upon any court that we go to, the desire on our part to do the right thing. In connection with these cases of loss of binocular vision, it seems to me the loss of binocular vision is a very serious matter. A man who has loss of binocular vision is practically devoid of the use of one eye because he has to cover by artificial means the other eye, in order that he may see, regardless of the fact that his vision may be perfectly good in either eye. The confusion of the double image destroys his ability to work. His other eye, is just as good, however; it makes no difference in many cases whether you cover one eye or the other, it is all right; you can cover either one and he can work very satisfactorily. But leave them both uncovered and the man cannot see properly. People who squint, in due course of time subjugate the vision of one eye and lose the vision of one eye as the result of amblyopia exanopsia. Perhaps a man who has had his head injured, in due course of time might be able to do that, but it really takes sometime.

President Hunter: Gentlemen, the motion made by Dr. Marsh is practical and patent, and very good. Are you ready to vote on the motion? All in favor signify by saying "aye;" contrary "no." The motion is carried.

Dr. Eagleton: Mr. President, Dr. Hagerty and Dr. Goodwin both have been doing a good deal of work for this Society in industrial matters, and I would ask at this time that they be requested to speak on this question. Nobody knows the amount of good that Dr.

Hagerty has been doing in trying to adjust medical fees.

Dr. John F. Hagerty, Newark: Mr. President, I am not interested in the computation of damages resulting from eye injuries, but I am interested in a phase of the subject that has to do with the Compensation Act. I have had wished upon me the very pleasant task of passing judgment upon the bills presented by physicians for attendance upon cases resulting from injury. It is not a very pleasant task, and I wish there might be some method of computing, mathematically, just what a physician's services are worth. It would help us out very much in our dilemma. The question may arise in the minds of the physicians throughout Essex County as to with whom I have to deal, and there may be the feeling that perhaps we are not dealing fairly with them. I want to take advantage of this opportunity of saying to them that we are trying to be fair; we are going to be fair to all parties concerned. I am sorry to say that up to the present time some of the bills that have been presented for judgment have not been fair; they have been very unfair to the employer and to the insurance companies. I do not want to be unjust to the physicians or surgeons, and I want to do all that I can to show my appreciation of the work they are doing, but I must say that up to the present time many of the bills that have been presented have been unfair, and it is a difficult matter for one in our position, not knowing the circumstances of the case nor the amount of time nor trouble expended in the care of the various injuries, to pass judgment on the bills presented; so I have proposed to Dr. Holden, just as Dr. Sherman has done in this particular matter, that we get together; that is, that we physicians whose bills are being presented meet with the patient and the judge and Dr. Holden, who has charge of the compensation work in Newark, and talk the matter over, just so that we may be fair.

Dr. William M. Goodwin, Newark: I want to express my appreciation to Dr. Sherman for bringing this paper here before our Society. I think it was very opportune and a very valuable paper to the members of the Society, not only to the ophthalmologists but to the regular practitioner. We all have these cases occasionally and want to be able to send them to an ophthalmologist to determine the disability of the man, and we want to have a feeling when we send him to any ophthalmologist that he will give the man a fair decision. Up to a short time ago, we certainly have never been able to get a just decision as to the percentage of disability, on an eye or in any other part of the body. The fact is, we have no arbitrary rules given us in our State law, to determine disabilities of any kind—not even to the eye; and Dr. Sherman in bringing this paper here will probably be the means of establishing in our Compensation Law a table similar to that, or just like the one he presented, which will give all the ophthalmologists the chance of determining these disabilities correctly and uniformly.

Dr. Sherman mentioned one case of a limited field of vision, or a 10 per cent. disability, which he gave to a case where a certain portion of the field was blind. His table does not cover such a case, but it seems to me

perfectly possible for the physicians to get together and make a table that will give a certain percentage for a certain portion of the field. You may think that it can't be done, but with careful study I believe such a thing can be put into table form. The disability of joints has been mentioned, and that is something with which I have had more to deal, and I know it is perfectly possible for any physician, with the simplest tools, to determine the disability of the stiff joints, or a different member, due to lack of function of the joints. In disabilities of joints, of course the chief disability is due to the stiffness or lack of motion. There are other considerations that might be taken up, like deformity or change of contour, and all of that. That, we perhaps cannot measure except by a guess, but that can be added to a definite mathematical decision as to the amount of deformity from the stiff joint. A table can be very easily prepared to give every practitioner a chance to measure his stiff joints and loss of function in that way, and he can then go before the referee fairly, uniformly. There is no occasion for our being so varied in our opinions on these matters.

Dr. Sherman, closing the discussion: I will not take the time to further discuss the subject. I am sorry we have not heard from the Southern part of the State. I was glad to have several who spoke, agree with me as to the value of having employers of industrial labor make an examination and record before labor is employed. This is a very simple matter and can be done by a trained nurse with proper instruction. I have many times seen the need of it.

In the December Journal we will insert the papers presented by Drs. Stevens, Ewing and Soule, deferring those of Drs. Bell, Dickinson and Stewart until the January issue, as those three were discussed together. Dr. Cairman's will also appear in January.

County Medical Societies' Reports

BURLINGTON COUNTY

Daniel F. Remer, M.D., Reporter

The regular meeting of the Burlington County Medical Society was held October 10, 1923, at the Y. W. C. A. Club at Burlington.

Both the President and Vice-President being absent, Dr. A. L. Gordon, of Burlington presided.

Dr. Nathan Thorn, of Moorestown, read a very interesting and instructive paper on "Rampant Reminders Which May Help in the Diagnosis of Children's Diseases."

Dr. Charles A. Barnes, of Philadelphia, read a very interesting paper on "What May Be Done Within the Limits of the Best Present Day Obstetrics to Shorten Labor and Lesson its Pain."

After dinner the Society adjourned to meet in Mt. Holly in January.

CAMDEN COUNTY

F. William Shafer, M.D., Reporter

The regular fall meeting was held on Tuesday, October 9, at 2 P. M., Dr. W. H. Pratt, presided.

We had the pleasure of listening to an ad-

dress by Dr. J. Bennett Morrison, Recording Secretary of the State Society.

The following officers were elected: President, J. Edgar Howard; Vice-President, Charles H. Jennings; Secretary, Thomas B. Lee; Asst. Secretary, Joseph E. Roberts; Treasurer, J. E. L. Van Sciver; Reporter, F. William Shafer; Historian, Daniel Strock.

Our Historian, Dr. Daniel Strock gave a resume of each member of the Society.

We have had two deaths during the year.—Dr. Joel F. Fithian, and Dr. Samuel S. Bray.

Dr. B. Franklin Bugby was elected a member. Dr. E. Lloyd Strohm was reinstated.

The total membership of our Society is 95. There were 35 members present.

CAPE MAY COUNTY

Eugene Way, M.D., Reporter

An adjourned meeting of the Cape May County Medical Society was held at the Egg Harbor Inn, Beesleys Point, June 27, 1923. President Gandy in the chair.

Members present: Gandy, Tomlin, G. Dandois, Hughes, J. Dandois, Rulon, Haines, J. Way, C. W. Way, E. Way, Marcy, Petitt, Marshall; also Dr. W. E. Darnell of Atlantic City. Twelve ladies were also in attendance.

The retiring president in introducing the new president, Col. Gandy, said in part:

"It gives me great pleasure to have the privilege to introduce a man of the high standing and attainment of Col. Gandy, and the Society is honored by having him for a leader. Of the many things that might be said of him, we will mention but a few. He graduated from the South Jersey Institute and Jefferson Medical College; was one of the founders and a charter member of the Cape May County Medical Society. Entered the Medical Corps of the U. S. Army, with the rank of First lieutenant, rose rapidly to the rank of Captain. Major, Lieutenant-Colonel and Colonel. He served in various Army Posts in the U. S. and spent five years in the Philippines as Chief of the Medical Department; took an important part in the war with Spain. Was Professor of Military Hygiene at West Point for three years; was assistant Surgeon General for two years and Acting Surgeon General for one year."

President Gandy replied as follows: "I feel honored in being elected President of this Society, but think you have made a mistake; some younger man should have had the position for the Government has recently decided that I am too old for further service and has laid me on the shelf. I thank your President for his kind words and your Secretary, who was my room-mate in College for his continued friendship. I have always been interested in this Society, and no matter in what part of the world I have been, have always kept in touch with you and if it is your desire that I serve you as President I will do so to the best of my ability."

The President then introduced Dr. Wm. Edgar Darnell of Atlantic City who delivered an address on "Chronic Abdomen," illustrated by a number of x-ray photographs. Dr. Danell's paper was supplemented by Dr. Rulon who showed a large number of x-ray pictures and added greatly to the interest of the meeting. Discussion was opened by Col. Gandy and the of the Society was voted the speaker and Dr.

Darnell requested to have his paper published in our Journal.

CUMBERLAND COUNTY

Elton S. Corson, M.D., Reporter

The Cumberland County Medical Society held its annual meeting at the Hotel Commercial. The president, Dr. S. T. Day, presided. There was a good attendance, with visitors from the Gloucester and Atlantic County medical societies.

The election of officers resulted: Dr. Percy Lummis, president; Dr. E. C. Lyon, vice-president; Dr. H. C. Miller, secretary; Dr. W. L. Cornwell, treasurer; Dr. E. S. Corson, reporter; Dr. M. K. Elmer, annual delegate.

Subjects affecting the welfare of the society were discussed.

Dr. M. C. Burns, of Jefferson Medical College, neurologist, was the speaker of the occasion. His subject was "Lethargic Encephalities, or Sleeping Sickness." It is only of recent years that this disease has been recognized as an entity. It is known to be due to a specific germ which enters the brain and spinal cord through the membranes of the nose. While in many cases the symptoms may be somnolence, yet it does not always follow. A light fever with mental disturbances, including vision, hearing and movements of the eyes and at times the extremities. At first it was confused in children with infantile paralysis or in adults locomotor ataxia or other forms of spinal degeneration. In most cases recovery issues, but in a spinal puncture, which is extensively employed in other forms of meningitis, is not indicated as it scatters the germs and increases the area involved. Tonic treatment, with rest and electrical massage, produce the best results. The sera, so extensively employed in other infections, do not seem to have afforded any benefit. Care should be used in the selection of a bed as bed-sores often occur, an air or water bed being the most suitable.

The annual picnic held at Tumbling Dam Park, was well attended and an enjoyable time was spent in the bowling alleys, strolling through the park and in social recreation. Several members reported vacations spent in distant places, Dr. M. F. Sewell in Maine; Dr. Lyon at Phoenixville, Pa.; Dr. Reeves and family in Canada; Dr. Counell in N. Y. State; Dr. Gleason, Chincoteague, Va.; Dr. Watson, Ocean City; Dr. Corson in Mountains of Penn.; Dr. Reba Lloyd in Colorado.

ESSEX COUNTY

E. W. Murray, M.D., Reporter

The 108th Annual Meeting of the Essex County Medical Society was held on Tuesday, October 2, 1923, at 8.30 P. M., at the Academy of Medicine, Newark, N. J. About two hundred members attended.

Besides reports, elections and other regular business the following matters were listed for discussion: 1. Revision of Constitution and By-Laws; including (a) change in the Council, so that at every election some new names shall be added even if some are re-elected. (b) re-writing the Article on Discipline, so that the Society shall live up to its obligation to enact methods which shall maintain the good reputation, moral as well as medical, of the Medi-

cal Profession. This is not the medico-legal question of prosecuting illegal practitioners.

2. Any action concerning laws on the prescribing of Alcohol Medicines "for Medicinal Purposes Only."

The President of the State Society calls for names of any who will act on Standing Committees. The matters are:

1. Welfare Committee work on Legislation, affecting both the Medical Profession and the Public, such as Venereal Disease Control and Sterilization of Criminals and Insane.

2. Medical Defence and Insurance.

3. Workman's right to choose his doctor under the Compensation Law; Standardization of Disabilities from Eye Injuries.

4. Narcotics and Alcohol.

5. The Cults.

6. Medical Expert Testimony.

Will you volunteer for any work?

The County Society with like purpose of getting work done, calls for volunteers to serve on any of its Standing Committees.

What will you do?

Election of Officers: Dr. Medford Runyon, President; Dr. C. R. O'Crowley, Vice-President; Dr. F. W. Pinneo, Secretary; Dr. R. N. Rogers, Treasurer.

Councillors elected: Drs. E. W. Murray and G. A. Rogers for two years. Dr. C. C. Beling and A. J. Mitchell for one year.

GLOUCESTER COUNTY

Henry B. Diverty, M. D., Reporter

The 26th annual session of the Gloucester County Medical Society was held at Hotel Pitman, which was well attended by members of the society, their wives, delegates from other medical societies and a number of invited guests.

Dr. George E. Reading, Woodbury, presided as toastmaster and presented the speakers of the evening. The principal address of the evening was that delivered by Prof. E. J. G. Beardsley, of Jefferson College, Philadelphia, which was very instructive as it dwelt upon preventive medicine. In the course of his address Prof. Beardsley stated that smallpox, diphtheria and typhoid could be prevented—smallpox by vaccination and typhoid fever and diphtheria by injection of a serum. A child that is inoculated with the serum would be immune from diphtheria the balance of his or her life while for typhoid it would be necessary to inject the serum every three years. Dr. Beardsley said that the latest reports from tests from recent discoveries is to the effect that serum has been discovered that will prevent scarlet fever and measles.

Short addresses of a complimentary nature were made by Dr. David C. English, of New Brunswick, editor of the Journal of the Medical Society of New Jersey, and former Judge Davis, of Woodbury. The latter paid a high compliment to the medical profession in declaring his belief that it was the most unselfish body of men in existence, and in the great work of prevention of disease, it was greatly decreasing the doctor's income if not eventually putting him out of business. Dr. Hunter, of Westville, former president of the New Jersey State Medical Society, also responded to the request of the toastmaster.

The Salem County Society was represented

by Dr. James and Dr. Husted; Camden County Society by Dr. Emma Richardson.

HUDSON COUNTY.

Wm. Freile, M.D., F.A.C.S., Reporter.

The society was called to order at 9 P. M., October 2, 1923, at the Nurses' Auditorium, City Hospital, Jersey City, by President Dr. L. F. Donohoe.

Dr. F. J. Quigley, chairman of the Legislative Committee, told of the activities of this body in gathering evidence against alleged illegal practitioners. He mentioned that two detectives had been hired and showed results obtained, and gave figures proving the existence of a large number of chiros practicing without legal authority. This committee, acting with the Welfare State Committee, would among other things, have before them two topics. One a proposal to modify the method of expert testimony at trials—a committee from the Bar Association will act with the Welfare Committee to endeavor to evolve a satisfactory conclusion. Second, the Venereal Control Bill. The committee will prepare this bill, but before it is introduced into the Legislature this year, it will be sent to each county society and voted on before any definite action is taken.

Dr. Pollak was an advocate of the policy of medical men for medical jobs under the supervision of the State Society. He felt that the Governor should be thanked for the appointment of Dr. McBride as Commissioner of Labor, and Dr. Pollak advocated that every county society should likewise approve of the choice and so inform the Governor and make its newspaper propaganda. Dr. Quigley said that he had been an interne in St. Joseph's Hospital, in Paterson, and had known Dr. McBride ever since; knew him as a man who enjoyed a tremendous practice; marked ability; Lieutenant-Colonel in World War; well thought of by the citizens of Paterson. He felt that the State should be congratulated and agreed with Dr. Pollak. Therefore, the secretary was authorized to forward a suitable resolution to the Governor and communicate with the press.

Dr. Cosgrove said that owing to the summer holidays, the committee on Faison's Memorial, as a whole, had not yet taken any concerted action, and therefore reported progress.

Three new members were elected, and three applications were referred to the censors.

Election of officers was next in order and a Nominating Committee, consisting of Drs. Quigley, Opdyke, Londrigan and Pollak, announced their choice, and the usual voting proceeded. Dr. Chas. B. Kelley was elected president; Dr. E. J. Luippold, vice-president; Dr. H. H. Brinkerhoff, treasurer; Dr. W. L. Yeaton, secretary; Dr. William Freile, reporter, and Dr. Ballinger, censor.

At the conclusion of the usual routine, the genial and well-beloved president, Dr. L. F. Donohoe, thanked the society for its support during the past year, also for the honor of being selected as third vice-president of the State Medical Society, and promised to do his utmost to keep up the standard of both the Hudson County Medical and State Society.

He then, as it were, rolled noiselessly away (but not in his Rolls-Royce) to one of the ordinary benches, and Dr. Charles B. Keeley, the incoming president, took the chair and said, on accepting the honor bestowed on him, he did so with two distinct impressions: First, that of gratitude; he had been a member of the Hudson County Medical Society for thirteen years, and to have attained the presidency of the second largest county society in the State, was no small distinction. The second feeling was that of fear. To those who sit in the benches, the presidency may not seem so big a job, but as vice-president he had learned that to have a successful administration, one must have a certain amount of executive ability and he wondered if he possessed it. He asked for the co-operation of the entire membership. He had always tried to be active and do what he could in his own small way, and assured them that all suggestions or criticisms of a constructive type would be welcomed. He advocated the precedent that had existed in the society for six or seven years, whereby the vice-president became the president for the ensuing year, and the election of Dr. E. J. Luippold, as vice-president, showed that proper attention had been given to the matter. He hoped Dr. Luippold would work with him and that next year the precedent referred to would be maintained.

The State had selected Dr. L. F. Donohoe as third vice-president and he, with the president, Dr. Eagleton, intended to work hard to make the State Society successful, and Dr. Kelley felt that Dr. Eagleton was a sincere hard worker, and asked the members to give consideration to any communication they might receive from him. He said: The Hudson County Medical Society has over three hundred members. In the county there were about six hundred qualified physicians, many of them of good education. Most of them could be reached and many were waiting to be asked. He should like to see an intensive drive made to infold all the eligible physicians in Hudson County, and by next June the enrollment should be five hundred, which would give us as large a membership as Essex. There was an important year ahead for the Hudson County Medical Society; for instance, there would be considered the Academy of Medicine, and the memorial to Dr. Faison, of which he was in favor. Some eight years ago Dr. Frank D. Gray had this Academy affair in hand and his committee would not fall in line and he got discouraged and reported adversely. He felt that the Academy of Medicine could be put over, Faison's memorial could be there, and at the same time it would allow for other men who have gone before, or will go in the future, to be memorialized. He detailed, how by a bond issue and an increase in the yearly dues, the financial end could be assured.

He left these thoughts with the members, and asked them to make this a banner year.

Dr. Luippold in the chair: The question of having an insigna on a doctor's car, which would be officially recognized, created considerable discussion from Drs. Jaffin, Swiney, Luippold, Bortone, Quigley, Cosgrove, Pearlberg, Pollak, Yeaton, Opdyke and Kelley. Dr. Jaffin talked advisedly on the topic, and

had a motion that a committee of three be appointed, which was amended by Dr. Swiney of Bayonne, to three in each municipality in the county. Finally, on motion of Dr. Quigley, it was decided to appoint a committee of three to make recommendation at the next regular meeting.

In the absence of an expected essayist from Baltimore, Dr. Oscar Freund gave in detail the history of a rather unusual case. That of an Italian woman committed to the hospital with a stab wound of the abdomen across the right rectus muscle. She showed evidence of having lost a good deal of blood and was in shock. As the bleeding seemed to be progressive, she was explored and a great deal of blood found in the abdominal cavity. Investigation did not reveal an opening in the hollow viscera, and finally careful search showed a cut in the gall bladder, which was sutured, and owing to the marked distention, the abdomen was closed with difficulty. On the tenth day she developed broncho-pneumonia, later partially viscerated and as her general condition was too poor to permit of anaesthesia, she was carried along and the intestines gradually receded into the abdomen. At the present time she has only a slight opening in the wound.

Drs. Jaffin, Luippold and Quigley discussed at some length the public interest in medical and surgical topics, stressing the importance of having these matters presented to the lay press in an authoritative, readable and truthful manner, and asked that a committee be appointed to make recommendations the next session of the society.

Dr. Joseph Koppel said that in response to the request of the medical director, he had on short notice only been able to find one which he considered might be of interest. The young man he showed had been admitted on August 29th, with an extremely enlarged prepuce; the glands of the penis was swollen and a history of having had gonorrhoea three months before; a week before admission the swelling began and pain. Dorsal incision revealed a small ulceration, hard, undurated, about the size of a dime, Wassermann 4 plus. Under the prepuce a large mass (exhibited). The patient had two silver and six salvarsans and has been also on mixed treatment and inunctions of mercury. This mass has not been much affected. Even exposure to the air has no influence. A specimen had been that day given to the pathologist and report would be given later.

MERCER COUNTY.

A. D. Hutchinson, M.D., Reporter.

The Mercer County Component Medical Society met on October 10th, President Cotton presiding. Evidently the members were well satisfied with their vacations, as a large percentage were present and took keen interest in the proceedings.

The applications for membership of Drs. Child, Stone and Proctor were read and referred to the Membership Committee.

The society went on record as favoring legislation on venereal and sterilization matters, and will await the further report of the Welfare Committee on the workman's compensation and expert testimony bills.

Dr. H. B. Costill was elected a delegate-at-large on the Welfare Committee.

Dr. Cotton gave a very entertaining and instructive report of his visit abroad, describing in detail many of the later methods now being applied in mental conditions. He referred to the centralization of mental hospitals in Birmingham, under Dr. Graves, and the fact of there being 6,000 physicians to 40,000,000 people. In London where Dr. Cotton read a paper before the Psychological Society, he met Dr. Wm. Hunter, the originator of focal infection, who, with Drs. Watson and Sir Frederick Mott, discussed his paper. Dr. Hunter spoke at length on "Septic Anaemias," as he is greatly interested in blood work. Dr. Cotton stated that nearly all the papers treated the physical side of mental diseases.

The work of Lane on resection of the colon, following twenty years' work along this line, was particularly interesting, Dr. Lane expressing the opinion that resection was not necessary in all cases, that with the removal of the first and last kink in the descending colon and release of adhesions about this region, many good results were observed. Dr. Cotton expressed the opinion that the English were far ahead in their vaccine work, and that great strides had been taken in fields heretofore not explored.

Following a general discussion of the report, Dr. Cotton offered the facilities of the State Hospital to the physicians, who may desire to work out some of the ideas, with a view of aiding their patients.

Dr. Wm. Gray Schauffler of Princeton, annual delegate from the State Society to Portsmouth, was then called upon, and in a few well-chosen remarks spoke very highly of the warm cordiality that existed abroad, and the sincere hospitality that was at all times extended to him.

The usual committee, composed of the president, secretary and treasurer were authorized to proceed with arrangements for the annual banquet.

PASSAIC COUNTY

Leon E. DeYoe, M.D., Secretary

The annual meeting of the Passaic County Medical Association was held in the Chamber of Commerce Rooms, Paterson, N. J. on October 11th, 1923 at 8.45 P. M. Dr. Maclay presided.

The report of Treasurer showed a \$216.00 balance, with \$947.00 in the sinking fund.

The following officers were elected for ensuing year: President, Dr. John Ryan of Passaic; First Vice-President, Dr. Thos. A. Dingman of Paterson; Second Vice-President, Dr. Chas. R. Mitchell of Paterson; Secretary, Dr. L. G. Shapiro of Paterson; Treasurer, Dr. Sidney Levine of Paterson; Censor, Dr. J. A. Maclay of Paterson.

Annual Delegates: Drs. D. H. Mendelsohn, Hugh Gibson, Lester F. Meloney, I. Feigenoff, Norman Dingman, J. Roemer, L. E. DeYoe, Wm. Dwyer. Alternates: Dr. Chas. Murn, Peter Denton and Franklin J. Keller.

The following resolution introduced by Dr. John S. Yates was accepted: Resolved, That the Passaic County Medical Society has noted with particular satisfaction and appreciation the editorial of August 2d, 1923, published in

the Passaic Daily News, relating to the injustice and injury which is frequently caused to the Medical and Dental Professions by the premature publication of the names of parties involved in proposed suits for damages. It is well known that such publication is frequently used as a method of intimidation and we therefore congratulate Mr. G. M. Hartt, Editor of the Passaic Daily News, on the obvious justice of the policy he has adopted in refusing to publish the details of such suits until the merits of the case are proven.

The Society took this opportunity to congratulate Dr. Andrew F. McBride on his appointment as Commissioner of Labor of New Jersey. Dr. McBride in a few well chosen words thanked the Society for its good wishes and expressed his desire to efficiently fill the office to which he has been appointed.

SALEM COUNTY

William H. James, M.D., Reporter

The annual meeting of the Salem County Medical Society was held at the Memorial Hospital, on October 10, at 2 o'clock.

The Society had the pleasure of hearing Dr. F. W. Smith, of Philadelphia, who spoke on "Treatment of Nose and Throat Conditions."

Dr. Smith further illustrated his lecture with anatomical specimens, thus making it very practical. He also showed the best way to examine the throat and nose by having a living subject to demonstrate with the use of the mirror and lamp.

The following delegates from Cumberland County were present: Drs. Reba Lloyd, Mary Bacon and H. G. Mills. From Gloucester County: Drs. Ashcraft, Downs and Sahill of Philadelphia.

The following members were also present: Dr. Davis, Hines, Smith, Hilliard, Hummel, Ewen and Church of Salem.

Dr. Davies of Elmer, Dr. Summerill of Pennsgrove, Dr. Johnson of Pemberton, Drs. Husted and Thomas of Woodstown, and Dr. James of Pennsville.

This being the Annual Meeting, the following officers were elected of the coming year:

President, Dr. Franklin H. Church; Vice-President, Dr. R. M. A. Davies; Secretary and Treasurer, Dr. John F. Smith; Reporter, Dr. Wm. F. James; Permanent Delegates to State Society, Dr. R. M. A. Davies. Annual Delegate, Dr. David W. Green. Alternate, Dr. W. T. Hilliard.

Before the Society adjourned a rising vote of thanks was given Dr. Thomas, the retiring President, for his arduous efforts in securing such able speakers for the meetings during the past year.

The Society decided to have their meetings held every two months during the next year.

SOMERSET COUNTY.

Philip Embury, Secretary.

The annual meeting and dinner of the Somerset County Medical Society was held at the Bound Brook Inn on Thursday, October 11th, at 1 P. M.

The dinner preceded the meeting and the guest of honor was Dr. Wells P. Eagleton, president of the State Society, who gave a thoroughly enjoyable talk on the various plans of the Welfare Committee with special

reference to proposed legislation. This was followed by a general discussion in which many interesting facts were brought out.

The annual meeting elected the following officers for 1924: President, Dr. Philip Embury; vice-president, Dr. Frederick A. Wild; secretary, Dr. Anderson A. Lawton; treasurer, Dr. Runkle F. Hegeman; reporter, Dr. Dan S. Renner; censor, Dr. William H. Long; annual delegate, Dr. Lancelot Ely.

The treasurer's report showed that we are on a sound financial basis and have a substantial bank balance.

Members present: Drs. Ely, Embury, Fisher, Hegeman, Hird, Flynn, Lawton, Long, McConnoughy, Meigh, Renner, Smalley, Stillwell, Ten Eyck, Weeks and Wild.

UNION COUNTY.

Russell A. Shirrefs, M.D., Reporter.

The annual meeting of the Union County Medical Society was held October 10th at the Elks' Club, Elizabeth, about fifty physicians attending. Dr. George W. Strickland was elected president for the ensuing year; Dr. D. R. McElhinney, vice-president; Dr. Irving Lerman, secretary; Dr. Frank Steinke, treasurer; Dr. Russell A. Shirrefs, reporter. Dr. E. W. Hedges was chosen as censor. The annual delegates selected were Drs. Van Horn, Brokaw, Bowles, Vinciguerra, Laird and Emil Stein.

It was decided to send a letter of appreciation to Gov. Silzer, commending his action in appointing Dr. Andrew J. McBride, former mayor of Paterson, to succeed the late Gen. Lewis T. Bryant as State Commissioner of Labor. The appointment will come before the Legislature for confirmation. The society will also write to the State Senator from Union County, urging him to vote "yes" on this appointment.

Drs. Wm. B. Fort and J. P. Linke were elected members and Dr. S. Korngut was re-instated. Two others were proposed. The society went on record as being in favor of a suitable law providing for the sterilization of degenerates. A talk on "Welfare" was given by Dr. George T. Banker, the retiring president. After the meeting refreshments were served.

WARREN COUNTY

F. A. Shimer, M.D., Reporter

The Annual Meeting of the Warren County Medical Society was held on October 23rd, at the Hotel Belvidere. Dr. L. C. Osmun, the president, called the meeting to order.

Nineteen were present to greet Dr. Wells P. Eagleton, the President of the Medical Society of the State of New Jersey. Dr. Eagleton, who is also chairman of the Welfare Committee of the State Medical Society, spoke on the work of the Welfare Committee. He spoke of the fact that a Limited Practice Act with educational requirements and a Workman's Compensation Bill allowing the physician more fees and more time, if proper notification had been passed because of their efforts, and that the Welfare Committee was trying to protect the interests of the physicians of the State and to make the profession more respected. That expert testimony, as now conducted, is a disgrace and that a Board should be appointed,

consisting of physicians, who should give expert testimony at the request of the Judge; that forty-five per cent of the money spent in the state is spent for the care of defective mental, etc., and that the Welfare Committee believes that a sterilization bill should be passed by the next Legislature. He also said that his Committee wanted an expression of the Society as to its attitude towards such bills.

Dinner was then served because Dr. Eagleton had to leave on an early train. After dinner the Society again met and the routine business of the meeting was taken up. The Treasurer's report showed a balance of \$11.88.

Dr. George Homer Bloom, now located in Phillipsburgh, N. J., presented a transfer card from the Lehigh County Medical Society, and asked to become a member of the Warren County Society. His credentials were accepted and Dr. Bloom was elected to membership.

The matter of the many chiropractors, who are being chased out of Pennsylvania, locating in Warren County was next discussed and the Secretary and the Board of Censors directed to look up their standing and if they find they are irregular practitioners to report their cases to the proper authorities for prosecution.

Following the suggestion of Dr. Eagleton that an expression of opinion be given by the Society in the matter of the various bills proposed for the next Legislature, after discussion the following was the result:

"That it is the sense of this Society, at this time, that in the absence of an exact knowledge of the contents of the Veneral Control Bill, we do not feel like approving anything we know nothing about, and that we leave the matter in the hands of Senator Thomas Barber, a member of this Society. On the advisability of introducing an amendment to the Workmen's Compensation Act "to give the workman the right to employ his own physician," the Society voted "that they heartily endorsed this idea." On the question of the "Sterilization Bill for Feeble Minded, Habitual Criminals and Chronically Insane," the Society voted "that this Society, in theory, approve of sterilization, with certain safeguards in the law" and leave the matter in the hands of Senator Barber. The Society did not favor the suggestion "that the procedure in the present form of expert testimony be changed."

The following officers were elected: President, Dr. Arthur Zuck, Washington; Vice-President, Dr. Lawrence H. Bloom, Phillipsburgh; Secretary, Dr. F. J. LaRiew, Washington; Treasurer, Dr. G. Wyckoff Cummins, Belvidere; Annual Delegate, Dr. F. P. McKinstry, Washington; Censor for three years, Dr. H. B. Bossard, Harmony.

Dr. Thomas Dedrick, the representative of the Society in the State Welfare Committee made a report which was accepted.

Local Societies' Reports

Bayonne Medical Society

The Bayonne Medical Society held its first regular meeting of the season at the Elks' Club, on Monday, October 15th.

Dr. G. K. Dickinson of Jersey City read the paper of the evening. It was a beautifully written article, entitled "The Lad." In this paper Dr. Dickinson compared the hardships

of the present day medical student with those of the student of 20 and 30 years ago. The types of students, he stated, were about the same with the ideal type in the minority. He concluded with a plea that the intern, who is really a student finishing his studies, be given every opportunity to learn, and that staff men go out of their way to teach those boys, as much as they can.

The paper was discussed by Drs. Sexsmith, Donohoe, Foreman, Woodfuff, Larkey and McLaughlin. Dr. G. K. Dickinson closed the discussion.—M. C. Marshak, Reporter.

Camden City Medical Society.

This Society held its monthly meeting October 2, 1923 in the City Dispensary building. Major John T. Aydelotte, U. S. A., Professor of Military Science in Jefferson College, spoke on "Why a Knowledge of Missiles is Necessary to the Military Surgeon."

Essex County Anatomical and Pathological Society.—A regular meeting was held at the Academy of Medicine, Newark, on October 11th, Dr. Horsford presiding. The program was as follows: Dr. George Olcott on "Inflammation"; Dr. M. De Fronzo, on a case of rat-bite fever, cured by salvarsan; Dr. C. Englander on "Some of the Newer Methods of Spinal Fluid Examination in the Diagnosis of Syphilis," and a case of metastatic melanoma of brain; Dr. H. S. Martland on "Diseases of the Hemolytic-poetic System," with laboratory data showing blood destruction and blood formation.

Summit Medical Society.

William J. Lamson, Secretary.

The regular monthly meeting of the Summit Medical Society was held at the C. B. C. C. on Friday, October 26, 1923, at 8.30 P. M., Dr. Keeney entertaining and the president, Dr. Dr. Lawrence, in the chair.

The roll call showed all the members of the society present except Drs. Campbell, Bebout, English and Praeger. About ten guests from Summit, Elizabeth and other places were also present.

The speaker of the evening was Dr. Fred K. M. Allen of the Physiatrie Institute of Morristown, who gave a most interesting talk on Insulin. (Incidentally, it had been announced in the morning's newspaper that Dr. Banting of Toronto, the discoverer of Insulin, had been awarded the Nobel Prize in Medicine for 1923).

Dr. Allen described the preparation, properties, dosage and use of Insulin. He considers it the most valuable advance in medicine in recent times. While not a cure for diabetes, nor 100 per cent. effective, yet, if properly administered, with adequate dietary and laboratory control, its favorable results are striking. Questions were asked at the conclusion of Dr. Allen's address, and many practical points were further discussed and elucidated. A vote of thanks was tendered to the speaker for his instructive presentation of the subject.

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Other Medical Meetings

Academy of Medicine, Northern New Jersey

The meetings held in October were as follows: Stated Meeting, October 17, paper by Dr. J. W. Sherrill of the Physiatrie Institute, Morristown, on "The Uses of Insulin in the Treatment of Diabetes."

Section on Eye, Ear, Nose and Throat, October 8, Cases were reported by Drs. W. P. Eagleton, H. C. Barkhorn and E. S. Sherman, and a paper was read by Dr. Harry L. Alexander, of N. Y. City, on "Hay Fever and Similar Allergic Conditions."

Section on Medicine and Pediatrics, October 9. Several interesting cases were reported by Drs. E. W. Murray, E. G. Wherry, Julius Levy, and R. H. Scott of Newark, and Dr. Arthur Stern of Elizabeth.

Section on Obstetrics and Gynecology and on Surgery, October 23. Cases were reported and Dr. H. C. Bailey, of New York City presented a paper on "Puerperal Sepsis."

Dr. H. J. F. Wallhauser is President and Dr. E. D. Newman, Secretary of the Academy.

New Jersey Tuberculosis League

The seventeenth annual meeting of this League was held in the Hotel Stacy-Trent, Trenton, on October 26th and 27th, Dr. B. S. Pollak, presiding. On the morning of the 26th a business meeting was held, in the afternoon the Nurses' Session was held with a word of greeting by Dr. Pollak and addresses by Miss E. G. Fox, National Director, Red Cross; Mrs. Gesell, of New Haven; Miss C. M. Inglis, the League's Field Nurse; Dr. A. M. Car, Medical Director, State Education Board; Mrs. M. J. Gemmell, Supervisor of Education, Trenton and Mrs. E. T. Hoffman on "Health Work in Hunterdon Schools." Dr. S. B. English, Glen Gardner, led the discussion.

In the evening the Medical Session was held, Dr. Pollak presiding. After welcome by Mayor Donnelly and the President's address, Dr. L. R. Williams, Director of the National Association spoke on "Education of Forms of Work for the Preventive of Tuberculosis," and Dr. Alex. Armstrong spoke on "Tuberculosis and Public Health." On Saturday a "Nutrition Program" was observed with Miss L. H. Woodruff, R. N.; Dr. F. W. Maroney, Atlantic City; Mrs. E. R. Grant, Washington, D. C., and others taking part. A trip to the Municipal Colony, Trenton, followed.

American Medical Editors' Association

The fifty-fourth annual meeting of this Association, held in the Auditorium Hotel, Chicago, Ill., October 25th and 26th was one of unusual interest as the papers and discussions were exceedingly practical and helpful. The subjects presented, after the address by Dr. F. W. Martin, Director of the American College of Surgeons and the presidents' address by Dr. H. O. Marcy, were: "The Medical Economic Situation," Dr. Ochsner; "Oration of Full Time Clinical Teachers in Medical Education," Dr. Bonfield; "The Hospital Situation in Its Relation to the Profession," Dr. Decker; "The Medical Editor's Attitude Toward the Recent Trend of Events," Dr. Achard; "Patents and Trade Marks," Dr. Stewart; Saving the Amer.

Clinical Industry," Dr. Bardick; "Maternity Welfare Without Governmental Bureaucracy," Dr. Chapman; "The Necessity of Educating the Public," Dr. Atkinson; "The Illinois Lay Educational Campaign," Dr. Whalen; "The Laity's Idea of the Physician," Miss Keller; "The Obligations to the Medical Profession of America of the Independent Medical Press," Dr. Coe; "The Relation of Manufacturing Pharmacy to Progress in Therapy," Dr. Souther; "The Lighter Vein," Dr. Free; "Ministers to the Sick," Dr. Mallory; "Relation of the Medical Journal to Public Affairs," Dr. Lewis; "The Daily Hospital Clinic for Private Patients," Dr. Keating; "Eye, Ear, Nose and Throat Conditions in Relation to the Impaired Mind," Dr. Stuckey; "Experience in Gland Transplantation," Dr. Grant; "Lamentable Social Facts—The Morals Court and Control of Venereal Disease Peril," Dr. Stone; Geriatric as a Special Branch of Medicine," Dr. Thewlis; "The Association of Life Insurance with the Medical Profession," Dr. Maxon. The Report of the Committee on Maternal Welfare of the Amer. Association of Obstetricians, Gynecologists and Abdominal Surgeons was also presented by Dr. G. C. Mosher.

New York Laryngological Society

The celebration of the 50th anniversary of the founding of this society, which as announced by the New York Academy of Medicine will take place November 15, 1923, commemorates an event of unusual interest. As far as can be learned this organization, now the Section in Laryngology of the Academy is the oldest society in existence of the department which it represents. In connection with the celebration there will be an exhibition representing the important contributions made to the progress of Laryngology in the City of New York.

Miscellaneous Items

Dr. Mayo Predicts Longer Life Span.—The average life of the human being has been prolonged from twelve to fifteen years as a result of recent advances in medicine and surgery, Dr. Charles H. Mayo of Rochester, Minn., declared at the meeting of the Manitoba branch of the American College of Surgeons. Dr. Mayo predicted progress already made would be surpassed in the years to come. He emphasizes the need of education as the prime requisite in the battle against disease.

The Modern Physician.—With the emergence of medicine from the mysterious, no less a revolution has occurred in the practitioner of medicine. While a good bedside manner is still a valuable asset, and will so remain in so far as it connotes a sympathetic and human attitude towards the sick and suffering, and while from a business point of view a good shop front no doubt has its value, no longer are the doctor's brains assessed by the sheen of his tall hat or the length of his frock coat. Like medicine, the doctor has become less mysterious, less aloof from and superior to his fellow men. Knowing more he has become less omniscient. Standing on surer ground he has become less pretentious. The medical

priestcraft, reminiscent of a time when the medicine man was more priest than physician, and more charlatan than either, has disappeared or is disappearing. This is all to the good, and tends to a more enlightened confidence between doctor and patient.—Childe, C. P.: Environment and Health, Lancet.

Doctor Paid to Keep a Man Well.—Five years ago a Philadelphia doctor was paid by the president of the Baldwin Locomotive Works to keep him in good physical condition for ten years. He made a contract with the doctor in which he agreed to pay a flat sum every year for being kept well, increasing this sum each year on the assumption that the older he grows the more difficult it will be for him to keep well. Under the contract, if Mr. Vauclain falls sick, a deduction is made from the doctor's annual retainer according to the length of time of his illness. He says: "Since the inception of this contract I have kept my part of it, and my doctor has kept his, except once or twice. I have been examined not less than every two weeks and have guided myself entirely by the doctor's instructions. In that time I have not lost a day from business, nor have I been ill in any way. I am heavier, stronger and more active than I was five years ago."

Rest a Prescriptive Medicine.—Rest is really a potent medicine to be prescribed and "dosed out" only according to the requirements of each individual case and with discretion, by physicians who understand its use. Discipline, regulation of life, is really the keynote to success in treatment—with rest always the basis.—A. K. Krause: Rest and Other Things.

Life Assurance and Welfare Work.

The Wesleyan General Assurance Society, which was one of the offices which recently announced a scheme of periodic medical examination of policyholders, has now inaugurated a health service bureau to carry out an extensive program of welfare work. This scheme is intended to supplement, not to replace, the existing agencies operating for the same purpose. The work of the bureau will include the preparation and distribution of literature bearing on personal and civic hygiene, the rudiments of health and the prevention of disease. Machinery will be set up for the study of morbidity and mortality statistics, and periodic health surveys will be made. Whatever will promote health and longer life will be within the range of the service. The society hopes that its efforts will merit the attention of health officers all over the country, and that it will be permitted to render such assistance to them and to the ministry of health as lies within its powers. The society has direct relations with nearly two million policyholders, whose homes it is called on to visit for the collection of premiums, in most cases, weekly. It holds that actuarial research indicates that the cost of health and welfare work will be abundantly justified by the saving of mortality. But it is also "actuated by the desire to render a very real service to the whole community."—London Letter, A. M. A. Jour.

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DAVID C. ENGLISH, M. D., Editor, 65 Paterson Street, New Brunswick.

Each member of the State Society is entitled to receive a copy of the JOURNAL every month. Any member failing to receive the paper will confer a favor by notifying the Publication Committee of the fact.

NOTE.—The transaction of business will be expedited, and prompt attention secured if,—

All papers, news items, reports for publication and any matters of medical or scientific interest, are sent direct to THE EDITOR, New Brunswick.

The County Society Secretary shall send promptly to Dr. Morrison, Secretary of the State Society, notice of the election of every new member, with his address; also of any changes of members' addresses.

All communications relating to reprints, subscriptions, extra copies of the JOURNAL, books for review, advertisements, or any matter pertaining to the business management of the JOURNAL are sent direct to THE CHAIRMAN OF THE PUBLICATION COMMITTEE, Newark.

OUR 1924 ANNUAL MEETING.

June 5th, 6th and 7th have been selected as the days for holding the 158th annual meeting of The Medical Society of New Jersey next year, and Haddon Hall, Atlantic City, has been engaged as headquarters.

THE McKEAN TABLET.

Before this issue of our Journal reaches our members, our Society will have performed one of the most notable and most worthy acts in its history—the presentation of a Tablet to the memory of our first President—Dr. Robert McKean—to St. Peter's Episcopal Church of Perth Amboy on the occasion of its 225th anniversary on November 4th, of which we gave notice last month. We expect to give an account of the presentation in next month's Journal.

We have this month departed from our usual custom of inserting papers read at the annual meeting in order of their presentation because we believed that Dr. Sherman's paper should appear this month as it relates to the work of our Welfare Committee this winter which is now being planned.

We regret that the space required for county society reports and our President's communication to the A. M. A. requires us

to omit some Original Articles we had planned to insert this month.

A LAY JURY MAY JUDGE YOU.

Doctor, do you ever have a bad result in a case? When you do, are you to blame? You can answer these questions readily. How would you like to have the questions answered by twelve laymen? You may at once object and say that laymen do not understand the intricacies of your science to which you have devoted a lifetime of study. You may say that it is unfair to be so judged by those uninformed in medicine and science. You may say that you will never be placed in the position of having twelve laymen decide whether you are to blame or not because you have given time and study to your profession and do the best you can. That is what probably one hundred and twenty-one members of the society who were sued last year have said, but their saying so did not save them from suit. A thousand physicians may agree that your treatment was proper and approved, but it takes but one physician testifying in court against you to say that the bad result to the patient was due to your use of improper methods and practice to place the decision in the hands of twelve laymen. How will the jury of twelve laymen decide? There is the rub. If you are sued for a bad result in a case, although you were faithful, conscientious and scientific in your treatment, you cannot escape the anxiety of the outcome or the humiliation of the suit. Why should you add to these discomforts the financial worry occasioned by the possibility of an adverse judgment? Why should you hazard the proceeds of your life's work upon a verdict of a lay jury? A small premium each year under the State Society's group insurance plan furnished by a reputable, efficient and financially sound company, will relieve you of every part of that financial liability arising out of your professional practice. If you have not already availed yourself of this protection, you can get information from your local agent or from the member of the Judicial Council for your district.

The above is taken from an editorial by G. W. W. in the N. Y. Medical Journal.

Perfect organization and thorough cooperation offers the only protection to our high standards of medical education and to future independence in the practice of medicine. In sickness insurance and state medicine lies the alternative.

YOUR STATE JOURNAL.

We most heartily endorse the following editorial by F. C. W. in the A. M. A. Bulletin, and commend it to our members for their careful consideration and action:

The journal of your State Society is your own publication and the official organ of you own society. As such it deserves your active support. If it is not so good as you think it should be, you can help to make it better. The State journal serves for the publication of scientific papers presented at the meetings of the State association and of county and district medical societies, for recording and commenting on professional and organizational activities, for maintaining contact between component societies and their members throughout the State and for keeping its readers informed about the comings and goings and the fortunes, good or bad, of their fellows in the State; and it serves also as a forum for the discussion of professional problems of the times.

You can lend real support and constructive assistance to your State journal in many ways. A few suggestions as to how your personal assistance may be extended are here offered:

1. See that what you write contains more than just a grouping of quotations and trite observations. Make it reflect your personal experiences and results. Strive to make your every day work produce something that will be helpful to your fellows in their professional labors and try to impart to them the worthwhile things that you have learned in the pursuit of your professional duties.

2. Read the editorials in your journal, and if you have personal opinions that are not selfish, tell the editor about them. Discuss with him and with your fellow members the problems of the day in your community and State, and record your judgment as to the best solution of these problems.

3. Urge the officers of your county medical society to report the meetings of the society and the activities of the profession in the county to the journal. If these officers are overburdened, offer them your aid in the preparation and transmission of such reports.

4. Let your friends in the profession throughout the State know what the physicians in your community are doing. Send news notes and items of social interest to the editor of the State journal. Your professional friends are interested in you and

the State journal can promote and maintain friendly associations throughout the State if you will help do it. Your friends want to know when you are married, when you become a proud father, when your community honors you, when good fortune shines on you, and, yes, when you are dead. If you are not heard from, they may think you dead.

5. Your annual dues and the dues of your fellow members in the State medical association do not produce nearly enough money to pay the cost of your State journal. The editor and his associates are constantly busy making up the difference by securing advertising contracts. These can be secured, but they cannot be continued in force unless the other persons interested in them, the advertisers, receive returns on their investment in your journal. Those products advertised in the State journal are dependable, because none but reputable concerns are permitted to advertise. When you buy what is advertised in your State journal, you buy standard products.

6. Read your State journal, from cover to cover. Probably this should have been our first suggestion. At any rate, it is desired to impress you with its importance. The reaction will come which will bring about improvement in a poor journal, if any such there be, and will make a good journal better if the members of the State association will read it. Even in the poorest, there will always be found something helpful.

No matter how busy you are, your State journal and The Journal of the American Medical Association should be read at the first opportunity after they are received. The busier you are, the more you need to read them. The physician who does not read these journals is the man who does not progress—in fact, he is the man that retrogresses.

It is hoped that, in thus calling the attention of the readers of the Bulletin to the State medical journal, an expression of renewed interest in their State medical publications will be evoked from our Fellows. As this interest manifests itself, we will witness the development of a greater solidarity and greater unity of purpose, and of effort in medical organization and in scientific progress.

The October report of the Atlantic County Medical Society was not received until the November Journal was ready for the press. It will appear next month.

SERVING THE PUBLIC.

Dr. F. E. Peckham, in his recent annual address as president of the Rhode Island Medical Society, said:

"Medicine is a profession of service. This service is one, the chief aim of which is or should be to help the people in every medical way. If money is the physician's chief goal, his career is a failure and his real service ceases. * * * I firmly believe there is no class of men who give more of themselves for humanity's sake. Also, I believe that when a medical man gives of his skill and ability just to be helpful to some suffering human, especially when there is no possible material reward, he comes near to following in the footsteps of the humble Nazarene, who simply went about doing good. If this is so for the individual, how much more good could be done if medical problems directly affecting the public could be taken up in a large and in a public way, by such a body of men as is represented by the Rhode Island Medical Society."

Our New Jersey State Society, in the work of its Welfare Committee, Public Hygiene Committee and Committee on Health Problems in Education, is doing much for the public's welfare and our members are giving much of time and money in that service.

REINSTATED AND NEW MEMBERS OF THE MEDICAL SOCIETY OF NEW JERSEY

In addition to those published heretofore

Bloom, George Homer, Phillipsburg.
Bloom, Lawrence H., Phillipsburg.
Bortone, F., 2765 Boulevard, Jersey City.
Bramble, Halsey, Elmer.
Browner, Frank, Tom's River.
Burkley, Louis F., Phillipsburg.
Burns, Edward L., 269 Broad st., Newark.
Carpenter, Wm. H., Drexel Bldg., Phila.
Cassidy, S. H., Keyport.
Dedrick, Thomas S., Washington.
Duboid, M. S., 735 High st., Newark.
Durham, R. E., Manheim Apts., Atlantic City.
Fink, A. E., 262 High st., Newark.
Fischer, Armin, 25 Hillside av., Newark.
Fort, William B. Plainfield.
Ganley, Arthur, 390 Park av., East Orange.
Garrison, B. H., 23 Monmouth st., Red Bank.
Geyer, Elizabeth, 510 Grand av., Asbury Park.
Hausman, Samuel W., Red Bank.
Harman, Wm. J., 190 W. State st., Trenton.
Herold, Herman C., 1115 Broad st., Newark.
Jonah, Wm. E., 1710 Pacific av., Atlantic City.
Kasmann, Harold A., Long Branch.
Korngut, Samuel S., Elizabeth.
Leighton, Robt. L., Spring Lake.

Linke, James J. P., Plainfield.
Merten, H. C., 356 Summit av., W. Hoboken.
Moffat, Barclay W., Red Bank.
Nichols, S. H., 517 Broadway, Long Branch.
Peteler, Alois, Keyport.
Potts, Geo. W., 1408 Grand av., Asbury Park.
Povey, H. C., 23 Franklin st., Newark.
Purcell, William D., Phillipsburg.
Robinson, B. A., Newark.
Satchwell, H. H., 53 Milford av., Newark.
Scott, E. A., 40 Front st., Red Bank.
Sayre, W. D., Red Bank.
Strahan, F. G., 473 Broadway, Long Branch.
Stewart, Robt. T., Laurel Hill, Secausus.
Stone, Russell B., Phillipsburg.
Tilton, W. S., Manasquan.
Tucker, W. S., 205 Hillside av., Newark.
Tannert, Carl H., 331 33rd st., Woodcliff.
Teimer, Theodore, 19 Lincoln Park, Newark.
Vail, John I. Blair, Blairstown.
Vail, William Penn, Blairstown.
Wescott, Frank W., Fanwood.
West, Guernsey, F., Phillipsburg.
Yadkowski, E., 637 High st., Newark.

WELFARE COMMITTEE MEETING.

A meeting of the Welfare Committee, together with presidents and secretaries of County Medical Societies and working committee chairmen was held September 30, 1923 at the call of Dr. Wells P. Eagleton, President of the Medical Society of New Jersey.

Representatives were present as follows:

Atlantic County—Drs. Clarence L. Andrews, William J. Carrington.
Camden County—Drs. A. Haines Lippincott, H. L. Rose, Alexander Macalister.
Essex County—Drs. Wells P. Eagleton, August Mitchell, E. S. Sherman, Christopher Beling, Guy Payne.
Gloucester County—Dr. James Hunter, Jr.
Hudson County—Drs. Frederick J. Quigley, Wm. J. Sweeney.
Hunterdon County—Dr. Samuel B. English,
Mercer County—Drs. Henry B. Costill, Henry A. Cotton, Wm. G. Schaeffler.
Middlesex County—Dr. Arthur L. Smith.
Monmouth County—Dr. G. Van Voris Warner.
Passaic County—Drs. Andrew F. McBride, John McCoy.
Somerset County—Dr. Philip Embury.
Union County—Drs. George T. Banker, Norton L. Wilson.

Judge Frederick W. Gnichtel and Mr. W. Holt Apgar, of the New Jersey Bar Association were present by invitation.

Dr. Eagleton presided. He set forth the reason for the meeting as the inauguration of the Welfare Committee's work for the year. The members of the Medical Society of New Jersey, he said had made their presence felt in public affairs of the State for the betterment of conditions affecting public health and education. He told of the action of Governor Silzer, at the suggestion of the Welfare Committee, in naming a medical advisory board from a list of members of the State Medical Society submitted by the Welfare Committee. This committee will advise with the Governor, the Department of Institutions and Agencies, and with other State boards. Thus the physicians would be in touch with the State administration and would place at the disposal of the State the expert knowledge which they

possess that the public health may be advanced.

The Resolution with the Suggestion to the Governor for the appointment of the Medical Advisory Board and read by Dr. Eagleton is as follows:

There shall be formed a so-called "Medical Advisory Board," consisting of five physicians appointed by the Governor from a list submitted by the Medical Society of the State of New Jersey, whose duty it shall be to render assistance to His Excellency, or to the Department of Institutions and Agencies, or any department of the State Government, in matters pertaining to health policies, to the health of the State, or that of its wards, and to disseminate such knowledge among the Medical Profession with the purpose of placing the technical and scientific knowledge of the profession at the disposal of the State, and of interesting the medical profession in public health problems.

The Advisory Board shall be presided over by a Chairman selected by the Governor. They shall meet at least once a month or at the call of the Governor or of the Department of Institutions and Agencies. They shall serve without any compensation whatever, direct or indirect, for the period of the Governor's administration, or until relieved from duty by him.

The members of the Medical Advisory Committee are: Drs. Arthur L. Smith, New Brunswick, Chairman; John McCoy, Paterson; A. H. Lippincott, Camden; Francis R. Haussling, Newark; John J. Broderick, Jersey City. They serve without compensation. Dr. Eagleton urged the members to obtain a copy of the Literary Digest of September 22, 1923, and read the article in it on "What People Think of Doctors."

The question of the advisability and possibility of charging the court procedure for giving medical expert testimony was discussed. W. Holt Apgar, Vice-President of the New Jersey Bar Association and Judge Frederick W. Gnichtel, of Trenton, were present by invitation and presented their views. They later retired with Dr. Christopher Beling and Dr. Guy Payne for a conference. After the conference Dr. Beling reported that it had been decided to have three physicians from the Medical Society to meet three lawyers from the Bar Association to further discuss the proposition and to report on a plan of action.

An expression of opinion from the committee favored the holding of the annual convention of the Medical Society of New Jersey next year on June 5, 6, and 7 at Atlantic City. These dates will be recommended to the State Society Trustees.

There was a general discussion upon the advisability of re-introducing the Venereal Control Bills into the Legislature. A suggestion was made that power might be given to local boards of health to quarantine such cases. On motion it was decided to have the Welfare Committee proceed with the preparation of the Venereal Disease Control Bills and that copies of the bills be submitted to each County Medical Society for its approval before the bills were introduced into the Legislature.

Dr. Macalister, secretary of the State Board of Medical Examiners, reported that of 130 Chiropractors who applied for a license under

the amendment of the Limited License Law passed last year, only thirty nine passed and were granted licenses. He said that the ex-service men who had taken up Chiropractic in the rehabilitation work are seeking a license to practice Chiropractic without examination. Dr. Macalister reported that the State Board of Medical Examiners had refused to grant ex-service men a license under such conditions. On motion by Dr. McBride, the Welfare Committee indorsed the action of the State Board of Medical Examiners in refusing to grant ex-service men a license to practice Chiropractic without an examination.

Dr. Macalister recommended that a bill be prepared for presentation to the Legislature amending the Chiropractic Law of last year in which it would be made positively certain that all persons, whether ex-service men or not, would be required to take an examination before being permitted to practice Chiropractic. This recommendation was concurred in.

Dr. Quigley declared that there were at least 500 Chiropractors practicing in New Jersey without licenses. He said that the Hudson County Medical Society had defrayed the expenses of getting evidence on such in Hudson County, and that convictions had been obtained. It was recommended that the attention of the State Board of Medical Examiners be called to this violation of the law and that the board be requested to prosecute the illegal practitioners.

On motion the committee extended a vote of thanks to the physicians who had accepted appointment by the Governor to membership on the Medical Advisory Board, and to Dr. Andrew F. McBride for accepting the position of State Commissioner of Labor, which position carries with it the direction of the State's work for rehabilitating persons injured in industry. Dr. Eagleton spoke of the sacrifice Dr. McBride was making for the physicians and for the public at large in accepting the position, and this should be highly appreciated. He said that Dr. McBride had been a tireless worker as a member of the Welfare Committee in behalf of the objects that the committee had sought, and that through his appointment the physicians had received recognition as administrators of medical matters in the State which they had long contended for.

Dr. McBride was warmly greeted when he rose to speak. He expressed his appreciation for the kindly greetings, and said that he desired the aid of the Welfare Committee, and of the physicians as a whole, and in fact, every citizen who believes in the betterment of the condition of the people of the State. The rehabilitation work of the department, he said was of especial interest to physicians as it had to do with the restitution of the injured to normal condition or as nearly so as possible. He told of the work of the Bureau and said that his object was to have the newly-appointed Medical Advisory Board confer with the department, and that he was arranging now for a meeting between this board and the boards of the various State Rehabilitation clinics.

Dr. Andrews of Atlantic City presented two bills, for individual cases of Atlantic City physicians which had been refused payment by an insurance company. These, and the question of the advisability of seeking a law which would give the injured workman the right to

choose his own physician were referred to the proposed conference of the Medical Advisory Board and the boards from the State Clinics.

On motion by Dr. McCoy, it was decided to take no action with regard to a change in the workmen's compensation law until after the conference of the Medical Advisory Board and the State Clinicians which was to be held under the auspices of the Welfare Committee.

On motion the Secretary was directed to send a copy of the Welfare Committee Minutes to all county medical societies.

Dr. Eagleton urged that County Societies name from among their membership physicians particularly qualified in various lines to serve with the Welfare Committee as experts. He also called for the appointment of eye experts to serve with Dr. Sherman of Newark, on a committee to determine the formula for the setting up of the degree of disability sustained by eye injuries in industrial accidents.

Dr. Lippincott recommended the appointment of Dr. Alfred Cramer, Jr. of Camden and Dr. Quigley recommended the appointment of Dr. Wallace Pyle of Jersey City for Dr. Sherman's committee.

Dr. Quigley also urged that delegates from the Medical Society of New Jersey to the A. M. A. Convention be continued in office from year to year, as it was only by constant attendance that a person could acquire the knowledge and the experience to make him an influential member of the House of Delegates of the A. M. A.

After a general discussion on the advisability of seeking a law providing for sterilization of certain persons, in which various opinions for and against such a measure was expressed, it was decided to have a committee named to study the question and to report later to the Welfare Committee.

On motion it was decided to endorse the action of the Trustees of the State Society in urging upon every county medical society that it canvass its Senators or Senatorial candidates urging them to vote for the confirmation of Dr. McBride as State Commissioner of Labor, when his nomination is presented to the Legislature for confirmation.

On motion the Committee adjourned.

JOSEPH H. GUNN, Exec. Sec'y.

OUR STATE SOCIETY AND THE A. M. A.

The Following Communication has been sent by President Eagleton to the Officers of the A. M. A. and the Editor of its Journal

Medical Society of New Jersey,
Office of the President.

Newark, N. J., August 29, 1923.

To the President, General Manager and Board of Trustees of the American Medical Association and to the Editor of the Journal.

Gentlemen:

I place the following statement before you officially for use in your consideration of the resolution offered by the Medical Society of New Jersey at the last meeting of the House of Delegates of the A. M. A. which resolution the Medical Society of New Jersey, without a dissenting voice, instructed "all its delegates to use their influence and votes for its adoption." The resolution was referred to the

Board of Trustees by the House of Delegates of the A. M. A.

The resolution is a constructive effort to correct certain defects, and help to remove what is unfortunately too general all over the country, viz: A general and growing dissatisfaction with many of the policies of the Journal and Association as it is now conducted.

Protest or suggestions are apparently too often regarded as personal affronts.

From the very first of my association officially with the A. M. A., all my suggestions and criticisms have been for the good of the profession.

Starting with a respect for the Journal as representing American medicine my relations with it both in an official and private capacity has gradually demonstrated that too much attention is paid to the commercial aspects and that the A. M. A. itself contains defects of organization, both of which must necessarily cause neglect and sacrifice of the higher scientific and ethical interest of the whole profession and of its individual members.

I am not in any sense an aspirant for any position in the A. M. A. I am not a destructionist, I know how hard constructive work is, and write this as I have numerous previous letters in the interest of the profession.

New Jersey as expressed at its last annual meeting of both its Board of Trustees and House of Delegates proposes:

1.—That the Editorship be separated from the General Managership; and

2.—Ad interim meetings of the House of Delegates be held at Headquarters.

By these reforms it is hoped that some of the deficiencies which are enumerated in this letter may be corrected.

FACTS

The facts that such an alteration of policy is necessary are as follows:

1.—On April 17th, 1920, the following statement was made editorially in the Journal: "Osteopathic Colleges have been repeatedly inspected and when measured by the same standards as are applied in the grading of Medical Schools, no one of them could rank higher than the lowest class C Medical College."

Believing in the reliability of the editorial, I, as Chairman of the Welfare Committee of the New Jersey Medical Society, made this statement before the Legislators in the House of Assembly at Trenton, and when challenged for proof I called upon the Headquarters of the A. M. A. for specific information regarding the inspection of the colleges.

After a long correspondence it was admitted that the A. M. A. had not inspected the Osteopathic Colleges, with the exception of one in 1914 and two others at a still earlier date. The colleges HAD BEEN systematically inspected, however, prior to 1910 by the Carnegie Foundation, over ten years previous to the editorial. The writer of the editorial did not know the condition of the colleges when it was written.

If the Medical profession of New Jersey had failed to substantiate its statements (made on account of the Journal's editorial) it would have given credence to the claims of the "repressive methods of the Medical profession and the A. M. A." made by the osteopaths and chiropractors to New Jersey's legislative rep-

representatives, many of whom were very antagonistic to the profession.

Failing in such evidence from the A. M. A. we might have been defeated if it had not been for the evidence of the truth of our statements and the aid rendered us by the Medical Department of the Board of Regents of New York State. Immediately I wrote "I want your counsel (the A. M. A.) to understand that the Medical men of New Jersey believe that either such statements should not be made in the editorial Journal or it should be able to substantiate them."

As no attention was paid to this protest to Headquarters, on December the 27th, 1921, as Chairman of the Welfare Committee of the Medical Society of New Jersey, I wrote a letter stating the facts to the President of the A. M. A. He presented this matter to the Board of Trustees and an inspection of the Osteopathic Colleges was ordered.

I had to appeal to the President of the Association before an effort was made to verify the statements in an editorial or to have work performed which had been assumed by the Association.

2.—In conjunction with the osteopathic and chiropractic problems I submitted two articles both of which contained facts which were advantageous that the profession should know, but they also contained criticisms of the policy of the Journal. These articles were returned with long explanatory letters, most of which had nothing whatever to do with the articles.

If the articles returned had been simply general papers such as read before a local society, their return might have been in the interest of good editorship, but they were the result of our dearly bought legislative experience obtained not in a private but an official capacity. Their object was not to exploit any personal aims or views, as they were not on scientific but on medical, ethical and political subjects; the result of experience by a group of doctors of New Jersey, obtained fighting without pay and at great personal sacrifice of time and money, for the interest of the whole profession.

The fact that it was the fruit of such an effort would have, in a policy of vision and interest of the profession, called for insertion even if the editor had been compelled to edit them in certain places.

I am returning one of these revised as suggested. It was, and is, an effort to furnish to the profession an understanding of one of the problems of medical legislation as we see it in New Jersey. The article that I now return to the Journal was my address in June, 1921 as third Vice-President of the State's Society and Chairman of its Welfare Committee. It has been revised and brought up to date.

3.—In 1921 the Medical Society of New Jersey was compelled to call upon all physicians to help in its campaign against an attack on Medical educational standards by the chiropractors and osteopaths. The Society itself spent many thousands of dollars to say nothing of the endless amount of work by the individual members. At one time there were one thousand physicians present at Trenton. The campaign was well organized and although an appeal to the A. M. A. for information was made it failed to furnish needed assistance, because of apparent indifference to its importance.

During the campaign, arguments and voluminous literature were prepared to answer the attack on "educational standards." The Medical profession of New Jersey had to hew its way for itself without assistance, and although the Headquarters of the A. M. A. knew from our correspondence, from submitted articles, and from personal interviews of the facts; and that we regarded that all of this material should be in the possession of the A. M. A. and made available to other States, (thus saving a repetition of effort by other States) **no attention whatever was paid to it by Headquarters.**

The failure to avail itself of our dearly bought experience and difficulties shows the inefficiency and indifference of the Headquarters of the central organization of the A. M. A. in the interest of the profession.

That a protest if directed to the President or a Trustee is of avail is shown by the fact that the following year, 1922, on our second appeal a representative from Headquarters came to Trenton. While we are grateful for this visit the fight had been won the previous year.

4. Possibly an aftermath of our protests and correspondence was an invitation extended by Headquarters to the Legislative Committees of New Jersey, New York, Delaware and Connecticut, to meet for a conference in New York in 1922. Several members of the Welfare Committee of New Jersey, attended and wasted a whole day as the representative of Headquarters presiding had no policy outlined. To our minds a most favorable opportunity to do something for the profession of the States was missed by lack of proper leadership based on intelligence and preparation; as several of the States represented had had considerable Medical legislative experience. As far as we could make out, one of the chief aims of Headquarters in calling the meeting was to make the men, (who had given up their time in legislative effort for the profession of the different States, and had discovered the indifference of Headquarters,) feel that the Association belonged to, and was conducted in the interests of the individual members; as this was the chief point of the Chairman's address.

None of the Officers, Trustees or Members of the Council calling the meeting was present, although at least one of its Members of the Council resided in New York and another would have been compelled to come a distance but little farther than some of the Members of the Committees of the different States present, some of whom came considerable distances in their eagerness and desire to be of service to the Medical profession.

The report of the Council submitted to the House of Delegates at the next Annual Meeting of the A. M. A. shows that three such meetings were held in different sections of the Country; that the Council's paid Secretary presided at each but fails to mention the attendance of a single member of the Council at any of the meetings.

This is to be expected in the present plan of organization of the A. M. A. with a General Manager and a Secretary of the Council to take care of all ad interim work, thus leaving little to be done by the Members of the Council itself, unless its personnel be such that it insists on taking an active part.

The failure of the different Members of the Council as a whole and individually, to take personal interest in the activity, and to avail themselves of the experience of the men of the different States—men who had, at great personal sacrifice tried to solve problems which are vital to the whole profession—is certainly not conducive to the development of the feeling of esprit-de-corps which is so necessary for the success of the profession. This weakness goes through the whole organization because of an absence of a democratic type of organization.

Such subcouncil meetings should not be held once, as in the past but every year, immediately, following the legislative sessions of the various States. They should be presided over by the Chairman of the Council, or at least by the Members of the Council who reside in the section. Its Secretary should be present as its Secretary having at his disposal all information. A constructive policy, the result of the experience of the men present, guided by the experience of other States, could thus be formulated.

5. I sent a book for review to the A. M. A. with a letter addressed to Dr. George H. Simmons, Editor Journal of the A. M. A. It was neither acknowledged or reviewed, but about four weeks later its title appeared in the list of "Books Received."

I then tried to have the book advertised in the Journal and found that the first page of the Journal had been sold to a Publishing House on a yearly contract.

On November 18th, 1922, I wrote, "As a Delegate to the A. M. A. I wish to say that I am very much opposed to the policy that you have adopted for advertisers; I think the Journal should be reserved for the interest of the profession and that the commercial attitude should be entirely eliminated. To give a contract to a commercial house for a season for the most advantageous space in the Journal is against good ethics."

I think I am voicing the opinion of all the profession when I state that the Journal should be primarily for the benefit of the whole profession in all particulars. Its most desirable advertising space should be available to all the profession and to different Medical publishers. As it is now conducted it places the interest of a purely commercial firm above that of the whole profession—for the sake of money to be regularly obtained. It is not good ethics.

No recognition of the Book having been made, the matter was stated to a Trustee of the A. M. A. He spoke to the Editor and the Editor immediately acknowledged the Book. The Editor's letter contained a compliment on the work and a statement that he had ordered it reviewed. His letter crossed one of mine, both written in May 1923, many months after the delivery of the book. During his time the Book having had many favorable reviews in different Journals, I was forced to the conclusion that the Journal's failure to review the Book was not because it was not of sufficiently scientific interest or was of too limited value to the profession as a whole to warrant a review in the Journal (both of which would have been proper grounds for its rejection) but had resulted from inefficiency or neglect on the part of the Journal. In my letter I

demand of the Editor that it be reviewed or at least decline to review it.

On May the 19th, I wrote as follows: "My experience with the Journal has shown me how discouraging it must be for poor men—to have their own Journal used for any of their work. Your policy of making the Journal a paying institution solely is of course resented by every scientific man, and it is in the interest of the poor fellow who may devote a lifetime to writing a book of scientific interest that I am sending this to remind you that there are higher motives than simply running a paying Journal."

The correspondence that followed would make it appear that in the absence of the Editor-Manager no one was instructed to examine all books received and it consequently had been automatically "filed"; no effort having apparently been made to distinguish the value of the Book. I was informed that the chief reason why so few books are reviewed was because reviewers could not be found to promptly write reviews. But of greater importance, is, that the Editor-Manager apparently regarded it as a personal matter; the only reason he was called upon even to acknowledge it at all was a personal one. If a book appears in the list of "Books Received", that ends the Journal's responsibility; this without any regard for the value of the book to the profession, scientifically or otherwise.

We object to the policy that a physician must ever be compelled to go to a Trustee before his scientific work is examined by the Editorial Staff.

The following week the Journal reviewed the book. In the meantime the book had been submitted to other Medical Periodicals which had perceived that it was a sincere effort to place a certain group of diseases on a more scientific basis and thus lessen the present high mortality. It was reviewed by them because any such effort, no matter how imperfect, must warrant and receive the consideration of the profession.

The Journal of the A. M. M. was the only Medical publication in which any special intervention was necessary before it was considered. And this in spite of the fact that the Journal is the one Medical Periodical not controlled by private interests but belongs to each and every member of the A. M. A.

The President of the Medical Society of New Jersey objects to such a policy of indifference and evasion; New Jersey believes that such incidences would not occur if the Editor's time was not largely taken up as General Manager. That if the business interests of the Association be divorced from the ethical and scientific aspects, a wiser and better policy in the interest of the profession would be adopted. For New Jersey believes that the obvious purpose of the Journal of the A. M. A. should be the upholding of legitimate individual interest of its members and the wise disseminations of their collective endeavors; the expression of collective policies and individual views in print, with such editorial comment as may be most helpful to the readers. That such publication must be primarily accurate and of a high order in every detail.

No fair or constructive criticism should be suppressed in the Journal. The Review Department as now conducted should be reor-

ganized. The notice at its head that the printing of the names of books as received must be taken as "a sufficient return" should be removed and a systematic effort inaugurated to make every member feel that his work at least has received proper attention and has not been perfunctorily "listed."

Every book and every contribution from a member of the profession should be carefully examined and when of scientific or ethical interest to the profession a conscious effort should be made by the Journal to encourage the contributing members in his effort.

To do this the Editorial Department must be so organized that it can render aid in the editing if necessary.

The policy of rejecting articles because of hard and fast rules and slight literary differences (while in itself good) can easily become a detriment to the profession's welfare. A conspicuous instance of which has come to my attention in Europe—when an American physician who, almost unaided, has been for years fighting to preserve American ideals of ethical conduct and professional integrity, had his allegiance to the A. M. A. shaken by the rejecting of his article by the Journal on a most trivial pretext. The very fact of his place of residence; of his distinguished services during the whole war, the very fact that he had retained his American citizenship and as a physician was striving to help American medicine—would in a policy of understanding of the higher aims and interests of the profession and of vision have called for the publication of his article. The article in question was immediately published without alteration by one of the largest and most influential general Medical Journals in America.

6.—Immediately after the last Annual Meeting at San Francisco, I inquired of Headquarters of the A. M. A. the exact date on which the A. M. A. would meet in Chicago in 1924, as this year (1923) the Annual Meetings of New Jersey's State Society and the A. M. A. had conflicted; thus preventing attendance at San Francisco of Delegates. I am now informed from Headquarters that the Trustees will hold a meeting in October when the exact date of the meeting of the A. M. A. will be decided upon. This unnecessary delay of four months compels all State Societies to either wait until fall before appointing their time of meeting or else risk having it conflict with that of the A. M. A. as happened to us this year when all Delegates from New Jersey were compelled either to cut out their Annual State Society Meeting or be unable to attend the House of Delegates of the A. M. A. The delay is working a hardship on New Jersey. It is a small matter but shows a lack of understanding and consideration to the interest of the individual State Societies.

I have written frankly; whenever I have touched the Headquarters of the A. M. A. as New Jersey's representative or in a personal capacity, I have but too frequently found indifference and lack of understanding of scientific and ethical ideals and a failure to appreciate its responsibility in the interest of the profession as a whole. I have no doubt that there are many explanations to temper condemnation. I have not the slightest suspicion that anyone of them has been intentional or personal; but that they are too general for

the profession's welfare there can be little doubt.

They are, New Jersey thinks, largely due to a weakness in the organization's plan itself.

NECESSITY FOR NEW JERSEY'S RESOLUTION.

The House of Delegates meets at a time during which every member's mind is naturally in some one of its scientific sections. It more or less perfunctorily transacts business, necessarily largely prepared for it, and then adjourns to hand over the interest of the profession for a whole year to a Board of Trustees and General Manager. No small body of men no matter of what a high degree of integrity can properly reflect the general sentiment of the profession and its interest, unless they are infrequent contact with its individual members as represented by the House of Delegates.

The Journal under this plan has become what was to be expected; conducted scientifically because of the immense amount of scientific material at its disposal—but failing in the one thing that to our minds is of more importance than any financial success, viz: the development of the love and affection and through them utilizing the service of the individual. This can only be accomplished by a policy of helpful aid and encouragement by the organization itself and by the Journal to every individual member who is striving to be of service, and by such effort adding strength and importance to the profession's standing in the community.

The policy of today is sacrificing the chief strength of the profession, viz: individual efforts for the profession, by the individual Doctor; for a large experience in an official capacity has shown me that given but a fair chance of expression, the Doctors as a class are of so high a type of citizen and patriot that their capacity for constructive disinterested public service, both social and political as well as professional, is unbounded.

Whenever the profession as a whole has failed to fully avail itself of its opportunities and responsibilities, it has been because of the weakness of its organization, in not offering means of expression to the individual Doctor. Whenever this has been provided the response of the whole profession has been thrilling, as exhibited during the war; one of the most glorious pages of which was the immediate response of a vast majority of the profession and the uniform high grade of work of each individual volunteer Medical Officer. The government simply gave them the opportunity for service. As soon as the Surgeon-General's office appealed to the Doctors as Doctors to do that work for which they were qualified, the response was general.

It is a sad commentary on the A. M. A. that the plan of organization which immediately enlisted so many of the profession did not come from it but was furnished by independent Medical Agencies.

Today the average Doctor, all over the country feels that the A. M. A. is of great value to him professionally, in that it furnishes him a most excellent Medical Journal and scientific meetings—how could it be otherwise with the immense amount of material at its disposal—but that it has not in the past and

is not now playing the important part in protecting his interest as a member of the Medical profession which he thinks he has a right to demand. Whenever there has arisen in his State or the Nation a question which has affected him ethically, economically or politically and he has taken the trouble to appeal to Headquarters he has found indifference and evasion, as in the cases herein cited by New Jersey. By the time the House of Delegates has convened the problem has been decided, frequently detrimental to his interests. All because the Journal and the Association, as now conducted, are not really democratic and consequently, frequently fail to voice the highest ethical aims of the profession and of the individual physicians.

As New Jersey sees it, the defects enumerated above are largely the result of the present policy of having (1) the offices of the Editor of the Journal and the General Manager consolidated and (2) having but one Annual Meeting of the House of Delegates and this coincides with the Annual Scientific Meeting of the A. M. A.

The interests of the Association are now so great that the Editor can not devote sufficient time or thought to the Journal's scientific and ethical aspects but must give the majority of his time as a General Manager. Business knows no sentiment—in its nature it can have very little ethical vision. But medicine itself and the interests of the profession, individually and collectively should always be paramount, and with 80,000 subscribers and contributors, there should be little difficulty in preserving the latter without a serious sacrifice of the former.

The A. M. A. is such a large organization and the ethical, economic, educational, and public health problems that must be solved by the Medical profession are now so important that if the Medical profession hopes to have the Association represent it properly, its House of Delegates should have an ad interim meeting at least once yearly.

Each Delegate to the House of Delegates should be made to feel that they are really of importance as they are if their resources are utilized.

By an ad interim meeting at Headquarters so bringing numbers of men in annual touch with it, and a policy of vision in the Journal, each Delegate would understand that the Association was in reality his Association for which he would gladly make personal sacrifices because it really represented the interests of the profession.

Its President should be a power, in no sense largely a figure head. Its finances should be given the widest publicity and used for the highest good of the whole profession.

ACKNOWLEDGEMENT.

As the resolution introduced in the House of Delegates of the A. M. A. by New Jersey, is now before the Board of Trustees of the A. M. A. I would request, as a Delegate, that I and the other Delegates of New Jersey be communicated with as to its disposition.

If there are any inaccuracies in the facts above stated I will gladly have them promptly pointed out for correction so that no injustice may be done by me or by the State Society of which I have the honor to be

spokesman. The opinions and criticisms are submitted officially.

A copy of this letter shall be sent to the President, the Editor-General Manager and all Members of the Board of Trustees.

Signed, WELLS P. EAGLETON.

President of the Medical Society of the State of New Jersey and Chairman of its Welfare Committee, Delegate to the A. M. A. from New Jersey.

Hospitals; Sanatoriums.

Hackensack Hospital.—The new building was opened to the public for inspection September 15th. It will accommodate one hundred and sixty patients. This, with the one hundred and twenty-five beds in the old building, which will be used, gives the hospital a capacity of two hundred and eighty-five beds. It cost \$900,000. It was founded by the late Dr. David St. John; Dr. G. H. McFadden was the first interne and Dr. E. K. Conrad followed soon after.

The building is six stories high and has a basement and sub-basement.

Medical Board ex-officio: Edgar K. Conrad, M.D., Frederick S. Hallet, M.D., Alvah A. Swayze, M.D., G. Howard McFadden, M.D., Charles F. Adams, M.D. The superintendent is Mary S. Conklin, R.N., assistant Kathryn L. MacLead, R.N.

Bonnie Burn Sanatorium.—Dr. J. E. Runnells, Superintendent, reports as follows: On August 31st there were 252 patients in the Sanatorium, 137 males and 115 females. This included 76 children in the Preventorium. Since the last report 16 patients have been admitted, 9 males and 7 females. One of these admissions went to the Preventorium, there were two re-admissions. The admissions are classified as follows: Pretubercular, 1; moderately advanced, 5; far advanced, 10. The largest number of patients present at any time during the month were 252. Smallest number, 231. Present September 28th, 234, including 62 children in the Preventorium, and 67 out of county patients.

The Union County Board of Freeholders recently awarded a contract at \$13,478 for a reinforced concrete storage tank with equipment on the Sanatorium grounds.

Hospital Construction.—A new fifty-bed hospital building has recently been completed at Irvington.—A drive for \$50,000 is under way for the Christian Sanatorium, Midland Park.—The contract has been let for the erection of a \$60,000 nurses' home for the Monmouth Memorial Hospital, Long Branch.

Hospitals and Pay Patients.—Charges that a number of Philadelphia hospitals refuse to admit patients who are unable to pay have been made by Dr. Philip Getson in a letter of complaint to Governor Pinchot. Dr. Getson cites the case or his inability to have a patient critically ill admitted until he had applied to seven hospitals, six of which absolutely refused to admit her. The patient was suffering from hemorrhage and was in danger of bleeding.

Deaths.

DE JAGER.—At Paterson, N. J., August 29, 1923, Dr. Simon De Jager, aged 67 years. Dr. De Jager graduated from the University of Leyden, Netherlands, in 1879. He has practiced in Paterson several years; was formerly city health officer.

GALE.—In Newark, N. J., October 6, 1923, Dr. George Bancroft Gale, of heart disease, aged 55 years.

Dr. Gale was born at East Shoreham, Vt., on April 29, 1868. Later his parents moved to West Springfield, where he received his early education. He was graduated from a Philadelphia medical school in 1896 and began practice at Rutherford. After going to Newark he maintained sanatoria at Verona and Butler. During the World War Dr. Gale was in charge of a base hospital at Jacksonville, Fla., having been given the rank of major in the medical corps.

Dr. Gale was named to the Soho Hospital board by Director Michael Barry of the Board of Freeholders on April 9, 1908. He resigned in January, 1910 in order to give more time to his private practice.

He was a member of the Essex County Medical Society and the A. M. A. For several years Dr. Gale was a member of the board of trustees of the New Jersey Automobile and Motor Club. He was guest of honor of the club prior to his leaving for his war work.

IN MEMORIAM.

Dr. Frederick R. Bailey, Elizabeth, N. J.

Died September 16, 1923.

The Union County Medical Society adopted the following resolutions:

"Whereas, The death of Dr. Frederick Randolph Bailey has brought to the members of the Union County Medical Society the keenest sorrow and regret; and

"Whereas, He was always an active and faithful worker in the interests of the profession of medicine, and his scientific attainments were of a high order, and the conscientious, unselfish service which he has rendered to the people of Elizabeth has endeared him to the hearts and homes of a wide circle of those who were fortunate to enjoy his professional services; and

"Whereas, His interest in and loyalty to the society as an active member have contributed largely to its welfare, each and every member of this society feels in Dr. Bailey's death the loss of a personal friend and an esteemed colleague; therefore be it

"Resolved, That it is the desire of this society to place on record this testimonial of our high regard for one whose memory will remain as an inspiration. To his bereaved wife and those nearest to him in ties of relationship, we tender our heartfelt sympathy.

"Resolved, That a copy of these resolutions be inscribed on a memorial page in our minutes, be published in the Elizabeth Daily Journal, and also be sent to the family of our deceased brother."

The Clinical Society of the Hospital also adopted resolutions, in which they said:

"Dr. Bailey's scientific attainments were of the highest order and he was admired and respected by his fellow practitioners. To his patients he was not only a good physician but a kind and helpful friend, and one who will be missed by a large number of our people. Though a busy practitioner, he found time to devote to the interest of his city, serving as a member of the Board of Education for several years. His passing away is a great loss to his friends, his fellow practitioners and to the city at large."

The staff of the Elizabeth General Hospital adopted the following:

"The staff of the Elizabeth General Hospital learns with deep regret of the death of Dr. Frederick R. Bailey, and wishes to extend sincere sympathy to the bereaved family.

"Dr. Bailey became associated with this hospital shortly after his graduation in 1896 from the College of Physicians and Surgeons of New York. He was also a graduate of Princeton University and of the Pingry School of Elizabeth. He received the first appointment as pathologist to the hospital, later being appointed consulting pathologist. Always associated with and interested in the medical department, he served as attending physician for nearly twenty-five years, being appointed in 1899. He wrote a textbook for students on histology and also other articles. Dr. Bailey was born in Elizabeth and followed his father's profession. Through his geniality and ability, he enjoyed a large practice and was highly esteemed by his patients. The members of the staff feel they have sustained a loss through his death and wish so to record their sentiments."

PUBLIC HEALTH ITEMS.

Newark Health Report.—The report of the Newark Dept. of Health shows for the month of July: 356 deaths during July or a death rate of 9.7 per 1,000 population. The principle causes of death were: 30; cancer, 34; apoplexy, 21; organic heart disease, 45; pneumonia, 13; appendicitis, 11; Bright's disease, 18. There were 953 births during the month.

New Jersey Death Report.—During the month ending August 31, 3,034 deaths were reported to the bureau of vital statistics of the state department of health. There were 414 deaths among children under 1 year of age, 144 deaths of children over 1 year and under 5 years and 1,036 deaths of persons 60 years old and over. The death rate for the month is 8.49, which is particularly low.

Bureau of Venereal Disease Control.—Dr. A. J. Casselman says: Reports of cases are useful, but the reports of sources of infection in all acute cases are essential to the control of the diseases. Syphilis is being controlled; gonorrhea can be if you will co-operate by reporting the source of infection of your acute cases. You may assure your patient that neither his name nor yours will appear in any way in the investigation; and by giving you the information about the source of his infection he will be helping the cause of public health with no inconvenience to himself.

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THE TREATMENT OF MALIGNANT DISEASE BY MEANS OF THE NEW HIGHER VOLTAGE SHORTER WAVE LENGTH ROENTGEN RAYS, RADIUM, AND ELECTROTHERMIC COAGULATION*

By **J. Thompson Stevens, M.D.**,
Montclair, N. J.

Previous to the past four years the treatment of malignant disease by means of radiation therapy was practically an empiric procedure. In only a few clinics widely separated throughout the world, were the results obtained in deep-seated malignancy good enough to warrant the hope, that future improvements in technique would place this method of treatment upon a thoroughly sound rational basis. To the results of the investigations of Seitz and Wintz in determining definite therapeutic doses in some of the diseases that can be successfully treated with radiation therapy, can be traced the comparatively recent improvements in apparatus and technique. These gentlemen have shown that 35% of a full dose of rays delivered to the ovaries produces castration, 60-70% is the sarcoma dose, 110% the carcinoma dose, and that 35-40% is the excitation dose for carcinoma. So that there will be no false impressions, here I wish to state that these men do not propose to have us believe that all we have to do in a case is to administer the above doses and that all will get well promptly. So far as I am able to determine there is no physician who can cure every case of any disease that comes to his hand. The above figures

are a basis for future investigations, and is one of the most valuable, if not the most valuable, contribution to modern medicine. The future will probably show that different types of cells in the various growths require slightly different intensities than those given above to produce permanent satisfactory results. The above determinations made it necessary for physicists, electrical engineers, and physicians to work hand in hand in order that practical methods of measuring radiation doses be determined and utilized, and the construction of roentgen ray apparatus capable of delivering the above intensities to any depth within the human body.

The new method does not consist of newly-discovered x-rays, but is a further development along well-known lines, as proven by the years of experience in the past. By increasing the voltage pressure upon an x-ray tube of greater dimensions and higher vacuum, rays are available of wave lengths approximating the gamma rays of radium. Therefore, the new treatment consists in the use of x-rays produced by extremely high voltage, which produces unlimited quantities of rays with penetrating power approximating the penetration of the gamma rays of radium. Physicists and electrical engineers have had no trouble in producing machines up to 350,000 volts capacity and even higher, but until lately, no American tube would stand such voltages over long periods of time. Dr. Coolidge has, however, produced a tube which will operate successfully at voltages up to 220,000 for unlimited periods of time.

In the past roentgen machines having a capacity of from 90,000 to 126,000 volts have been in universal use for therapeutic purposes, that is machines giving voltages equivalent of from a nine to ten-

* Read at the 157th Annual Meeting of the Medical Society of New Jersey, Atlantic City, June 22, 1923.

inch spark gap. The new apparatus will produce voltage up to 350,000 volts, that is voltages equivalent to a twenty-four inch spark-gap, or more than twice that in common use. For the present, however, we cannot use voltages above 220,000, because of the limitations of the best roentgenotherapeutic tube that has appeared to date. These extreme voltages produce rays whose wave lengths closely approaches the wave length of the gamma rays of radium and, therefore, from a given dose of radiation as registered upon the skin, there will be a higher intensity in the depths following the new methods of treatment than is possible under the universal technique. A comparison of the effects of the new, harder type of x-ray and the gamma rays of radium upon the living tissue at once shows that more penetrating x-rays have been produced and that we may look upon the new higher voltage apparatus as producing rays having practically the same physical characteristics as the gamma rays of radium. This discussion naturally rises two questions. Why go to all this trouble in the production of higher voltage roentgen rays? Why not use the radium? With radium we are so limited in our quantities of gamma radiations that we can only destroy cancer within three centimeters of our applicator, that is, with radium alone it is a physical impossibility to permanently cure cancer, except skin cancer. My friend, the late Dr. Russell Boggs, has clearly stated repeatedly that it takes approximately ninety-two grams of radium to equal the quantity of radiation coming from an x-ray tube working under the "old" technique. No one yet knows how much will be required to equal the total quantity of useful radiation coming from an x-ray tube working under the "new" factors. It is an economic impossibility to get even ninety-two grams of radium in any one institution in the world, seven grams is all that can be found in any one place at the present time. Therefore, I feel sure that you will agree with me when I say that if we are going to cure cancer by radiotherapy we must get our bulk of radiations to the disease by means of a roentgen ray apparatus. In this discussion I do not wish to go on record as being opposed to radium therapy. Radium has practically unlimited value when used with a thorough understanding of the physics of radiation

therapy. Personally, I am constantly using radium but I do not treat deep-seated cancer with radium alone. Here radium is used within the diseased area itself, when the patient's measurements are such that it is impossible to deliver a knockout dose with the roentgen rays, that is, I am using radium to bring up my local intensities of radiations in patients of great dimensions.

Filtration of the rays has undergone equally great and equally important changes. Rays of many wave lengths are emitted by an x-ray tube. All but the shortest wave lengths are worthless for the treatment of deep-seated disease. By means of filtration we are able to absorb all of the longer wave length rays. With the "older" technique, aluminum of from three to six millimeters thickness was used, while copper or zinc in from one-half to one and one-half millimeters thickness is used with the "new" technique. One millimeter of copper is about equal to twenty-three millimeters of aluminum. Filtration must be of such material and of such thickness as will give a homogenous radiation, which must be determined for each apparatus by physical and biologic tests.

Under the "old" methods of treatment we all thought it necessary to get our x-ray tube as close to the skin as possible. Physical measurements of the intensities obtained in the depths, say ten centimeters under the surface, show that to obtain the best intensities in the depths we must get the tube as far away from the skin as time will permit. Time of treatment is increased directly as the square of the distance increases. In actual treatment a focal distance is taken which will give us from 170 to 200 electrostatic units at the seat of the disease, employing the total number of ports of entry available. The necessary number of ports of entry are determined by the actual measurements of the case in hand and by the physical measurements of the intensities of the rays obtained in the depth by means of an iontoquantimeter. With my deep therapy apparatus focal distances used vary from fifty to ninety centimeters, according to the measurements in a given case, just explained.

Ports of entry, that is areas for the application of the rays have been remarkably increased in size with remarkable influence of the depth dose as a result. Formerly we all thought that it was ab-

solutely necessary to use many, often very small ports of entry, which is not a rational procedure in the light of our new knowledge of the part played by secondary radiations in bringing up our depth intensities of radiations. The most important of the secondary rays are called scattered rays. The scattered rays are of the same wave length and have the same physical qualities as the primary rays coming from the tube. It is a proven fact that the larger the port of entry, within certain limitations, the greater the effect of the scattered radiation becomes.

Homogeneous roentgen radiation allows us to saturate each centimeter of tissue with a radiation of nearly equal intensity from the surface to the disease, that is about one-half the rays reaching the skin reach to a depth of ten centimeters under the skin, or according to the value of the particular apparatus one is using. The conditions just mentioned are practically the opposite of the conditions obtaining in radium therapy. No matter how, when, or by whom radium is applied, it is a physical impossibility to secure anything like a homogeneous radiation. Radium needles and emanation seeds were conceived to overcome our inability to get homogeneous radiation with radium, but to date have absolutely failed. To produce complete destruction beyond three centimeters with radium in either large or small quantities it is necessary to produce irreparable damage to nearby normal, healthy tissues, which is, of course, not a wise procedure. For instance, for a malignant growth of the cervix or uterus, if we are to stand any chance of getting the patient permanently well we must get to every tissue within the entire pelvis, whose external boundaries are the bony walls of the pelvis, a homogeneous radiation of an intensity corresponding to not less than 170 electrostatic units. If we place radium packs upon the skin, in view of the measurements of the smallest pelvis in existence, it at once becomes apparent that we can never get anything but an excitation dose of rays to the center of the pelvis, that is to the seat of the disease. By placing the radium within the cervix or uterus the periphery of the pelvis will receive an excitation dose of rays, the lymphatics will not be sealed, due to insufficient radiation, and we may expect early, perhaps, distant metastasis,

and failure from such treatment. The proper procedure here is to ray from the outside with a homogeneous roentgen radiation, under proper methods of focal distance, proper size and number of ports of entry, as determined by actual measurement of the patient, and actual measurement of the intensities of radiation that the apparatus is delivering in the depths with an iontoquantimeter. Should the measurements of a particular case be so great that it is impossible to get to every tissue within the pelvis a homogeneous radiation of not less than 170 electrostatic units, then one must make up any deficiency in radiation intensities from within the cervix or uterus with radium. Just how this is done in actual practice I will illustrate in a few moments by means of lantern slides of cases worked out on plotting paper. However, I am sure that you will be better pleased if I cite an imaginary case here. I will take an extremely hypothetical case so that those of you who are not actually doing this work will not fail to grasp what is necessary for the radiation therapist to do when a case is sent for radiation therapy, likewise such a case will cut down complicated explanation.

Let us take a case of carcinoma of the cervix in a patient whose pelvis is a perfect circle with an anterior-posterior diameter of 20 centimeters. The diseased cervix we will suppose is exactly in the center of the circle, that is 10 centimeters from all surfaces. Now with the treatment factors, that is the milliamperage to the tube, the kilovoltage, the focal distance, the filter, and the size of the port of entry, that have been found to give the best depth dose with the particular apparatus one is using, let us proceed to give 170 electrostatic units over the anterior surface. Let us suppose that the iontoquantimeter whose ionization chamber has been placed within the vagina at the cervix shows that we are getting 55% of the radiation reaching the skin to the cervix. All that is necessary now in order that the cervix may receive 110% of 170 electrostatic units is to repeat the same dose through a posterior port of entry. In this case two ports of entry were used to get the dosage. In the same case let us suppose that our apparatus only delivered to the cervix through a single port of entry 27½%. In this case it would be neces-

sary for us to use four ports of entry, anterior, posterior, and one from each side. Again let us suppose in the same case, or in a case of greater dimensions, that is impossible for us to get 110% of a full dose to the cervix employing the total number of ports of entry available, here we must get all we can from the roentgen apparatus at hand and make up any deficiency in radiation intensity with radium from within the cervix.

In carcinoma of the breast the location of the disease calls for an entirely different method of treatment. Instead of being located virtually in the center of the body, it is only from three to five centimeters under the surface. Depth dosage is increased by increasing the distance of the tube from the surface, also by increasing the thickness of the filter. If the distance has not extended beyond the limits of the gland, it is treated through one anterior port of entry, the exposure in my work lasting as long as five and a half hours in some instances. If the disease has extended to the mediastinum for instance, then we must ray from the back and sides in addition to the anterior raying. The measurements here with the iontoquantimeter cannot be made upon the actual patient for obvious reasons. We must make use of the water phantom. Water has practically the same absorbing powers, etc., as the human tissue. Placing the ionization chamber of the iontoquantimeter five centimeters under the surface of the water with modern therapeutic roentgen ray apparatus, it is possible to get 90% radiation to a depth of five centimeters, and it is an easy matter to make up the missing 20% by burying radium needles or emanation seeds throughout the mass.

As to the dangers accompanying this new method of roentgenization, it can be said that the higher the voltage, that is, the shorter the wave lengths used, the less the danger of damage to overlying and surrounding healthy, normal tissues. This statement is made on the assumption that one using this method of treatment has had the necessary training and experience that makes for sound radiation therapy judgment. Also the above statement is borne out by my own observations in my own clinic as well as in the clinics of others who are using the "super" roentgen rays. The only reactions in my hands that have ever

caused any anxiety have been those observed in cases of cancer of the breast with extensive metastasis into the lungs. The symptoms presented by such patients are: Shortness of breath, dry cough, sensations of tightness throughout the chest and harsh breath sounds with sometimes dry rales. Almost all of the cases having the above mentioned metastasis have developed this condition following treatment and all except two, recovered. The roentgen findings in such cases have been those of fibroses, that is healed metastatic nodules.

Intensive treatment of any part of the neck is occasionally followed by temporary aphonia. Some of the less severe reactions are temporary dryness of the mouth and throat, and oedema of the uvula. Diarrhoea, bladder and rectal irritation are commonly present following efficient treatment of the pelvic viscera which is likewise temporary. Damage to the blood was a troublesome condition in the days of the "old" roentgen treatment. With the "new" methods it is found that on an average the blood constituents are only reduced by about 5% and that the normal is regained in from a few hours to a few days. Nausea and vomiting are still very much in evidence when deep treatments are given, especially over the chest and upper abdomen. However, I have about made up my mind that nausea and vomiting does not appear quite as frequently as in the "old" days and that when it does appear it is not so great and does not last so long.

Whether this new method of treatment is going to be productive of more lasting results than the older method has, time alone can show. However, in Germany, where the method has been on trial for several years, some surgeons have given up the knife in certain forms of malignancy, at least, because of better final results obtained by radiation therapy done. Here in this country the immediate results are so much better than those obtained by the older methods, that it is reasonable to expect many more permanent cures in the future than have been obtained in the past. There is no question as to the value of the old method. Many, including your essayist, have gotten some practically hopeless cases permanently well with it, while unheard of palliation has been accomplished in hundreds of other cases. However,

with the new method, in a series of unselected cases, more cases are cured or relieved of their suffering than in the past. In the strictly localized or operable cases nearly 100% can be cured by a combination between a skillful surgeon and radiotherapist. From 80% to 90% of the strictly borderline cases, that is those just beginning to show metastasis, can be gotten well. In the inoperable and hopeless cases the results are, of course, not nearly so good. Soon I hope to be able to present statistics of the results obtained in carcinoma treated by radiation therapy and surgery, as practiced by some of the leading eastern surgeons with whom I have the good fortune to be more or less closely associated. Many of my surgical friends are demanding active postoperative radiation, others insist upon both pre- and post-operative radiation. To date our statistics show that the best results are obtained, particularly in the borderline cases, that is, those that are just beginning to show metastasis, in the cases that have pre-operative radiation. This observation is in harmony with experimental work, that properly radiated cancer cells will not grow when transplanted.

Electrothermic coagulation is a method of treating certain forms of malignancy, or certain localities, that have become affected with malignant disease. Dr. George Wyeth has described the same method of treatment calling it endothermy because of the coagulating effect of the high frequency current due to the resistance of the flow of the current through the tissues thereby producing extreme heat within the tissues while the applicator remains cold. This method is superior to the actual cautery because by varying the size of the active electrode destructive heat can be obtained within the diseased tissues at great distances from the point to which the electrode is actually applied. The actual cautery, as you all well know, only heats to destruction the tissues in close proximity to the field of actual application. For this work it is necessary that one be equipped with a high frequency apparatus with a capacity of 1,000 to 2,000 milliamperes. The patient is placed upon one large electrode, usually the buttocks are placed upon it, well soaked in water. The other electrode is usually a point, that is, the electrode with which we actually destroy the disease is usually a

point. Coagulation has several advantages over any other method, some of which are: At no time during the operation are the lymphatics or blood vessels opened. The same current that coagulates the disease, seals the lymphatics and blood vessels. Because of the former there is less chance for metastasis and because of the latter the operation is bloodless. During the operation we must make sure that all of the disease is destroyed. The coagulation should begin in the healthy tissue, the diseased tissue being destroyed last. When the coagulation is completed to lessen sloughing we may at once remove the diseased tissues by cutting them away, always keeping well within the coagulated area, or we may allow the whole to slough away itself.

Electrothermic coagulation is one of the most efficient, if not the most efficient, methods for the removal of malignant disease without subsequent metastasis or recurrence of both known today and it is unfortunate that all localities affected by malignant disease cannot be treated by it.

Combined with radiation therapy electrothermic coagulation can be used to advantage in leukoplakia, cancer of the tongue, epitheliomata, by suprapubic cystotomy for cancer within the bladder, malignant tonsils and other locations within the mouth, and lately I have used the method for malignancy of the cervix, and with some success with the aid of a sigmoidoscope for malignant tumors within the rectum and sigmoid. It is the only method of treatment that offers any hope of cure in malignant dermatitis caused by roentgen and radium rays. In this latter group of cases it is, of course, not preceded or followed by radiation therapy.

Conclusions

1. The determination of definite therapeutic dosages of rays required, together with the perfection of an iontoquantimeter for measuring the radiations, are the greatest achievements to date in radiation therapy.

2. The "new" higher voltage, shorter wave length roentgen rays are a distinct step forward. They, combined with radium, permit a homogeneous radiation of any depth within the body to be given, without the dangers of the "old" methods of damage to nearby normal, healthy organs.

3. Radium should not be used alone in the treatment of any form of malignancy that has extended beyond the skin or that lies under the skin. The best use for radium is from within a malignant process, to bring up the local intensities to the required amounts.

4. Strictly localized cases should be treated surgically, plus pre- and post-operative radiation.

5. Some definitely inoperable cases can be gotten well with radiation therapy skillfully carried out.

6. The hopeless cases should be treated by the older methods of fractional dosage simply for palliation. The new method, by causing rapid destruction of cancer cells, is very apt to produce a fatal cachexia, due to absorption of necrotic debris.

7. When it is possible to use electrothermic coagulation, we should not hesitate to use it. It is one of our best agents to successfully destroy malignant disease.

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DISCUSSION.

Dr. Joseph H. Wyatt, Newark: Deep X-ray Therapy is primarily a question of dosage, since it is definitely proved that, under certain well-defined conditions, an abnormal cell will die after an exposure to the xrays that is insufficient to destroy normal cells. To increase the depth dose we require hard tubes which give the shortest wave length, and suitable filters to absorb the longer wave length, and have as nearly a homogeneous radiation as possible. That living tissues undergo certain changes after exposure to the xrays and some kinds are more sensitive than others, has been

known for several years. The changes seem to be primarily in the nucleus in the matter of chromatin. The nucleus is the most highly organized part of a cell and chromatin is radio sensitive. The nucleus disintegrates the cell vacuolates and breaking down is carried away by the lymphatics. The more embryonic the type the more susceptible is it to radiation.

Dr. Stevens has mentioned the approximate percent. of the skin dose required to produce various results. He mentions carcinoma dose, 110 per cent. Thirty-five to 40 per cent. stimulates, and 60 to 90 per cent. paralyzes. The carcinoma type is the more resistant type of the malignant growth. The hard, slowly grown scirrhous type is more resistant than the soft encephaloid. The difficulty of sarcomatous growths is early dissemination. Before treating a condition, we ought to know the location, extent and type of the tumor, and its relation to the surrounding structures, as well as of the existence and location of metastatic foci. Then, we decide the effective wave-length for that case. You sometimes hear of a so-called cancer dose. Due to various factors, there cannot be such a term possible, because we do not know enough about the biophysical and pathological phases of tumor growth, and we do not know the quantitative and qualitative effects of xrays on different tumors of the same type. It is true that radium is only local in action and that xray must be used on account of the areas to be covered and to include the lymphatics that drain the area. Surgery cannot be entirely disregarded in the treatment of malignancy. In the case of a large mass, the resulting toxemia following deep therapy treatment can be reduced to a minimum by removal of the mass, but it is the consensus of opinion that these cases do better if given anti-operative radiation to seal off the lymphatics and post operative radiation should follow. Electrocoagulation as well as surgery should be conservatively regarded in cases of malignancy showing metastases.

Dr. Joseph E. Roberts, Camden: I have enjoyed the doctor's paper very much. I have not myself had any experience with this high voltage x-ray treatment. I have done considerable with the nine inch spark-gap machine, and I think that we can match some of the results on the epitheliomata with that treatment that were mentioned by Dr. Stevens. It is a subject which when I have tried to familiarize myself with, has rather caused me fright and fear. It seems to require a knowledge of electrophysics—One ought to be a physicist almost to understand the ionization chambers and the ionquant meters and all of that. It certainly is not a method of treatment, because of its dangers, which the tyro should attempt. It certainly is, I believe becoming the method of treatment to use the x-ray, and I believe that we will all come to it eventually.

Dr. Frank J. Keller, Paterson: I would like to ask Dr. Stevens what his experience has been with glands of the neck. Regarding what the preceding speaker said about obtaining results with a nine inch spark-gap, I might say I think that is old. Twenty years ago with the twelve inch Queen coil experimental

work, I could show as good results as that, but I will say it was done in the dark; we had no means of measuring it. I think the great thing in Dr. Stevens' paper is in reference to the methods of making measurements and giving accurate dosage in these cases.

Dr. Jacob Roemer, Paterson: Dr. Stevens has covered the principles of radiation therapy thoroughly. This method was started in Germany in 1916, and for the first few years they gave the entire dose, say from six to ten or fifteen hours, and found that when those massive doses were given, in a good many cases the reactions were so severe that the patient would develop leukemia or pernicious anemia, due to the rapid destruction of the blood. The results of Dr. Stevens are very excellent and I congratulate him upon them. As to the matter of measurements of doses, it is still an unsolved problem. I would like to know the distance of the focus skin used when you get ten centimeters in the depth? Fifty-two per cent. of the anathema dose is much better than I have seen in my own experience or abroad. I think he is getting much better results than the German machines can produce, because the best I have seen abroad is about forty per cent., measured according to Dessauer's chart and ionization chambers, about forty per cent., ten centimeters in depth. Dr. Stevens stated that in cross-firing one must be very careful not to get more to the tissues than say one hundred and thirty per cent.; that beyond that it would kill the patient. I think that is a little bit too alarming. Some of the tissues can stand as high as one hundred and eighty, and of course the intestines will stand even as high as one hundred and sixty. The most alarming thing that can happen in ulceration at the point where you do deliver as high a dose as one hundred and sixty or more, but no very bad results or deaths have occurred from cross-firing at those points.

Dr. Stevens, closing the discussion: The discussion of any paper is oftentimes the most interesting part of the paper. I appreciate very much that we have had the type of men to discuss that paper who have come forward and had their say. The cancer dose is a method of dosing which is under a considerable amount of discussion. Some men say there is no such thing, and that they gave that dose and did not get the results. In my own clinic, we are quite apt to look at home. The Germans have been trying this method and using it for years and as time goes on they are still more in favor of it. If we have a case which we expect to show a reasonably good result within a certain length of time, and we don't get it, we start looking at home and see if we gave that patient the dose. Generally we find that something happened so that the patient did not get the dose. The cases which are absolutely localized or operable cases should have pre-radiation before surgery and post-operative radiation. Pre-radiation has the advantage of destroying a good many of the malignant cells outright. The lymphatics are closed. Therefore, when the surgeon goes in to remove this growth, metastatic cells cannot float off to some distant part of the body. Post-operative radiation is used to produce a new fibrosis around

the areas where the surgeon may have broken up the fibrosis formed at the pre-radiation. I might say to Dr. Roberts that with the nine inch machine he can do just as good work with that apparatus as anybody can do with the high voltage machine, if he spends the time at it, there is no question about that. The only thing is, with a low voltage machine you have to go around twenty hours' exposure to get a patient with a growth in the central part of the body, whereas with the higher voltage machine you can do it in eight hours; sometimes less, sometimes more, but not anywhere near twenty hours' exposure. That in itself is an argument for the high voltage machine: It lessens the strain on everybody—patient, operator, and everyone. Dr. Keller mentioned the adenitis. Of course, the dosage which has been worked out by our German friends is found to be 50 per cent. of 170 electrostatic units for adenitis. We do not treat adenitis, tubercular or otherwise, on the big machine. We do it on the nine inch machine, the small machine. The measurements, as Dr. Keller outlined, are most important. If you cannot make measurements, you have no business monkeying with the high voltage machine, because if you don't make measurements, you will have trouble. It is exactly the same as if I were to take somebody's appendix out: The patient would no doubt die; there is no question about it in my mind. (Laughter) If anybody starts to use these machines and does not measure his ray, he is going to have accidents, he is going to blacken the eyes of others in this work in the future, and all the good work that somebody else is doing will be more than offset by some of the bad results that this other man is going to get. As to Dr. Roemer's reference to the massive doses administered by the Germans, in some of the papers we have been led to believe that the Germans commonly transfuse their patients. That is perhaps true; but in this country, with our machines, German machines are questionably high voltage machines, they are not more than twelve inch voltage machines, according to our measurements, at the outside. In this connection I might state that the Germans were the first ones who discovered the principle of radiation therapy, but the Americans have gone ahead and perfected the apparatus. The only cases that are transfused in this country are the same cases that are going to be transfused if you are going to operate on them. You don't have to transfuse after treatment, you transfuse them before. Perhaps a patient with a cervix tumor who had bled a great deal would be transfused before operating. When I referred to the death dosage of 52 per cent., that was a hypothetical case I took—I wanted to make it as simple as I could, so that everybody would grasp it.

The Dessauer charts which Dr. Roemer mentioned show in some instances that Prof. Dessauer was able to get as high as 60 per cent. at a depth of 10 centimeters. It seems to be pretty conclusively proven that the intestines do not stand a dosage of radiation about 135 per cent. Dr. Roemer said 160, but I think the dosage is 135. Also at those points where the rays cross underneath the skin, perhaps a centimeter or two under the surface,

the radiation is quite apt to be considerably higher there than it is anywhere in your depth. If you get more than 130 per cent. at a considerable depth and that patient is left alone, the patient will die.

THE PREVENTION AND RELIEF OF HEART DISEASE.*

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The recognition of the importance of cardiac disease not only medically but sociologically and economically is a comparatively recent development. In New York City, where the organized study and care of this class of patients was first begun, the Association for the Prevention and Relief of Heart Disease was organized in 1915.

In considering this subject, it is necessary first to attempt to visualize the magnitude of the problem presented by heart disease and its importance, not only to the individual, but also to the community as a whole. Fairly accurate statistics are available on most of the points involved and in addition we know from personal experience that in patients suffering from heart disease, a certain degree of disability often exists for a great many years and that before death there is usually a period of complete disability and dependence upon others which may extend from several months to several years.

As to the incidence of heart disease and its mortality, reliable statistics are at hand. During the recent war special attention was paid to heart disease. The figures of the draft boards show that among men of military age the rejections for organic heart disease amounted to 30.74 per thousand, or about 3%. Of the men accepted by the local boards and subsequently examined at camps by special examiners, the rejections for heart disease amounted to 11.56 per thousand, or roughly 1%. Thus the total rate of rejections for this cause amounted to 42.3 per thousand, or approximately 4%. This means that among 5,000,000 men in the prime of young manhood, more than 200,000 were disqualified for service because of heart disease. In civil life statistics are more difficult to obtain. One company found that from 1915 to 1918 its rate of rejections for cardiac defects was large and carefully managed life insurance 24.4 per thousand or 2.44%, and this, remember, in spite of the fact that persons

with the severer grades of cardiac disorder are not likely to apply for life insurance.

From various groups of figures estimate has been made that 2% of the entire population of the United States have serious heart disease; in other words, about 2,000,000 persons. One industrial worker out of every 50 has been found to have a serious heart defect. In New York City, where most careful work has been done, it is found that about 1.4% of all school children have heart disease, a serious situation when you consider that these boys and girls are thus seriously handicapped at the very threshold of life.

Heart disease causes more deaths in this country than either pulmonary tuberculosis or cancer; in fact, it stands at the head of the list of causes of deaths. Cardiac disease is responsible for one death in every 6 or 7; pulmonary tuberculosis 1 in 10. It reduces the span of life about one-half,—the mortality in mitral regurgitation being 50 to 100% in excess of normal and other lesions show a still higher percentage. However, mortality statistics do not tell the whole story, for there is also to be considered the lives of invalidism, the economic loss thru reduced earning capacity and consequent hardship upon wife, children or other persons dependent upon the sufferer from heart disease and in the case of those holding positions of responsibility involving the safety of others, the menace to life.

Heart disease can be prevented or arrested or at least its progress slowed in the vast majority of cases. As in the control of pulmonary tuberculosis, Haven Emerson, who has studied the situation thoroughly, believes that similar methods are applicable to heart disease and his opinion has been borne out by the work in New York City and elsewhere. Young people, especially school children, would seem to be the class among whom this work could be prosecuted to the best advantage, thus getting the case before extensive damage had occurred and before they had assumed economic responsibilities which would, in a comparatively short time, result in their breakdown.

One problem in handling this situation, which is not peculiar to heart disease, is to bring the patient and physician together early enough. An analysis of 100 cases of heart disease at Bellevue Hospital, of probable rheumatic or tonsillar or choreic origin, showed that the period which elapsed between the date of the probable infection

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and the date when the patient learned that he had heart disease, either from his appreciation of subjective symptoms or by the statement of a physician, on the average was 5.36 years. The periods varied widely from immediately after the original illness up to 30 years. The solution, of course, is education of the physician and of the public just as was done in the case of tuberculosis. Hence this discourse.

The ages at which the communicable diseases mostly occur, which are chiefly responsible for the majority of cases of valvular and muscular disease of the heart, certainly fall in age groups under 35 years and a majority before the age of 10 years. Here then is the most promising point of attack and the greatest responsibility, for the solution of our problem therefore falls upon those having to do with children of school age and among this group most excellent results have already been obtained. In New York City one worker reports that in his group of cases supervision produced a gain of 13.5% in school attendance, or expressed in school days, each child gained three weeks of school attendance under special clinic and class care.

In order to intelligently plan to prevent a disease it is well to consider the common causes of that disease and those concerned in heart disease may be grouped as follows:

1. *Infectious Diseases*: Rheumatism, chorea, other manifestations of rheumatic type; commonest cause is diseased tonsils and teeth. Syphilis.

2. *Intoxicants and Poisonings of Various Sorts*: Worry, fatigue, intestinal toxemia, chronic foci of infection; (a, tonsils; b, teeth; c, sinuses, etc.); thyroid, alcohol, tobacco.

3. *Improper Methods of Living*: Sedentary habits; lack of outdoor exercise; over eating and improper eating; insufficient sleep.

A classification based upon the presence or possibility of heart disease and the functional capacity of the patient will also prove of great service and the following one adopted by the Association for the Prevention of Heart Disease fulfills all requirements: 1, Patients with organic diseases, but able to carry on ordinary physical activity; 2, patients with organic disease, but able to carry on ordinary physical activity; (a) activity slightly limited; (b) activity greatly limited; 3, patients with organic disease, but unable to carry on any physical activity, i. e., who must remain in bed or in a chair.

Patients with Abnormal Signs and Symptoms: Not believed to be due to organic disease. This diagnosis to be "not cardiac"—Class E."

Potential Disease: Patients without circulatory disease, but whom it is advisable to follow because of the presence or history of an etiologic factor.

Now as to the procedure to properly handle the problem of heart disease. One can do no better than to again quote Haven Emerson on this point. "Detection of patients with early or unrecognized cardiac disease is the first step of proper preventative management. Physical examination of all children admitted to schools, public and private, is advised. Re-examinations should be made once a year where practicable and always after an acute illness.

"The most effective and constructive service for prevention and relief of heart disease is that close co-ordination of school and clinic found where the examination of the children picked out by the school medical inspector is taken up by a clinic class operated in the school district, the chief of the cardiac class becoming the specialist adviser for the school and home career of the cardiac school child, just as the tuberculosis specialist has guided the anemic and pre-tuberculous child in the open air classes of the public schools."

Emerson summarizes the steps involved in prevention as follows:

1. "Control of infectious diseases, particularly rheumatism and syphilis."

2. "Care of teeth, tonsils and adenoids."

3. "Lengthening of the period of hospital stay and convalescent care after acute infections, particularly after rheumatism and tonsillitis." (This is difficult in many cases because of shortage of beds).

4. "Supervision of home after-care, preferably from a special cardiac class in a dispensary."

5. "More regard for 'growing pains' in children, commonly found to be of infectious or inflammatory origin, and their importance often overlooked."

6. "Supervision of nutritional defects."

7. "Avoidance of mid-age over-exertion, habits, intoxications, etc."

"Prevention of decompensation may well come under this heading. It is really the prevention of serious heart breakdown and is important. Prevention of heart over-strain in those with a recognized heart defect is an important service of special cardiac clinic for adults."

It is also important in children coming

to the age when they must take up some employment or plan future study looking toward their life work. To these should be added graded and supervised systems of exercise which do much to improve the general nutrition of the patient and to increase his cardiac reserve.

Minute attention to detail is the keynote of success in dealing with cardiac disease, it being necessary to inquire into and supervise every part of the individual's life and to do it systematically, regularly and persistently, no matter how well he may be, for only by so doing can repeated breakdowns and ultimate invalidism be avoided.

I have not mentioned drugs, although the common conception of the treatment of heart disease seems to be summed up in the use of digitalis. Most of the cases with whom we deal among children do not require drugs of any sort and one could ask for no more satisfactory results than are obtained by following the methods outlined above.

When the person with a damaged heart reaches the stage where the taking up of some type of work or the planning of a line of study, looking to his life work, the physician or social service worker, or both, must aid him in picking out that employment best suited to his abilities and the possibilities are many. The worse thing that you can do to one with cardiac damage is to prohibit him from taking up some useful occupation and condemning him to the idleness of semi-invalidism. Consider your properly treated and arrested cases as patients handicapped by some degree of cardiac damage and limited in their potentialities only by the extent of this damage. Many a person with extensive but arrested pulmonary tuberculosis has discharged responsibilities quite as great as those of the average healthy man and the loss of an arm or leg or sight or hearing does not exclude one from leading a useful life even though it does limit the choice of occupations. A mere recital of the occupations open to a cardiac and which have been successfully filed by such a one would consume more time than all of this paper.

Accounting, architecture, book-binding, basketry, and cane work and all kinds of clerical work. Light gardening, salesmanship, sewing, shoemaking, typesetting, tailoring, music, painting, carpentry and cabinet making, printing, working in the manufacture of light articles such as garments, biscuits, toys, wicker furniture, etc. Helpers at the lighter trades—electricians, op-

erating various types of machines, engraving and various types of work in the manufacture of jewelry. Ticket taker, doorman, elevator operator, light janitor work, time-keeper, etc., etc., are only a few of the possible occupations which have been successfully filled by persons with definite heart damage. Supervision and periodic re-examination are necessary even after the patient has taken up some profession or trade and the punctillious observance of this rule must be insisted upon.

This work has been instituted in many of the larger cities, especially in the east, and last year a national association for the prevention and relief of heart disease was formed under the leadership of men of national and international reputation. Due to the far-sightedness of Dr. George Holmes, Chief Medical Inspector of the Public Schools of Newark, New Jersey, the organized care of school children suffering from cardiac disease has been instituted there. The task was originally undertaken by Dr. Mandeville, whose excellent work was interrupted by his untimely death. It was reorganized again in the autumn of 1922 and is now going along very satisfactorily. The children are detected by the regular school examiners or by the school nurses and are referred to the cardiac clinic. Here, before the arrival of the physician, the child's history is taken by a nurse, who gives her whole attention to this work, and who is guided as to her questions by a printed form. Temperature, pulse, respirations and weight are also charted. This history is checked up by the physician in charge of the clinic and additions or corrections are made. A complete physical examination is then made and the findings charted accordingly to a printed outline which saves considerable time. Exercise tolerance tests are performed if they are necessary and the case is classified according to the table given above.

A certain proportion of these children do not have heart disease, although they may present some abnormal sound over the heart. These are referred back to the school from which they came with proper recommendations. In the other cases foci of infection receive attention. They are sent to a hospital for tonsillectomy if this has not been done previously, and to various other departments of the school clinic for sinus examination and dental work. The nurse goes to the child's home and attempts to interest the parents in our plans and makes suggestions as to diet, sleep,

fresh air, exercise and other matters of hygiene. If necessary, the child is put to bed for a period at home or in an institution. Proper cases are placed in the special exercise class for cardiacs where they are given graded sets of exercises under careful supervision. Some are able to continue in the regular gymnasium connected with the public school, with or without limitations. They return to the clinic about once a month or more frequently if they are not doing well. We do not, except in rare instances, prescribe drugs.

During the summer we were trying to get some of the children out into the country which is not ideal, since we were not able to supervise their activities. The arrangements under which the clinic is being operated are far from ideal or even adequate, but the Hospital of Saint Barnabas has recently offered us its facilities and the clinic will, in the near future, be operated as a department in the Out Patient Department of that hospital, which will be a long step forward.

In closing I would again emphasize:

1. The magnitude and seriousness of the menace of heart disease.

2. The need of careful, painstaking, sympathetic study of these patients and proper treatment, looking to the arrest of their disease.

3. Their rational classification.

4. Fitting them into the niche in the social structure where they can be of the greatest use, without harming themselves.

5. Careful, detailed life-long supervision. No patient with cardiac damage is so well that he does not need the oversight of a physician.

6. Do not wait for a cardiac case to develop symptoms of heart failure before you begin to take an interest in him, any more than you would wait for hectic fever, emaciation or hemoptysis before beginning treatment in a case of pulmonary tuberculosis.

Dr. Ewing after reading his paper showed a few slides illustrating some of the cases and the exercise work done at the Mineola Home for cardiac cases and also in the Burke Foundation at White Plains.

DISCUSSION

W. Blair Stewart, Atlantic City: The State Society owes a great debt to Dr. Ewing for presenting this subject of heart disease—Its causation, prevention and treatment. It has been most carefully considered, as the doctor has emphasized the proper time to treat disease is before one has it. The careful watch-

ing of the young child means more in the elimination of the possibilities of the heart disease of the future than probably any other one thing. The removal of diseased tonsils, teeth that are infected and the various foci of infection, will prevent many cases of heart disease. We must not lose track of the child, who grows very rapidly at a certain stage of life and may put on anywhere from three to six inches in stature in one year, when the growth of his heart muscles do not keep pace with that of the general body. Then you will find many cases of hemic murmurs, slight murmurs that really are comparatively insignificant, and yet that is the time when the child needs the most careful watching, that he does not produce a permanent injury to the heart valves. Many young boys entering college are subject to these hemic murmurs, murmurs that are too often called by the doctors whom they have seen, organic murmurs—They are not. The large proportion of them will disappear if these young men are put under precautionary exercises, the proper diet and the proper regulation of the hygiene of their bodies. The question of clothing of the young child is a great factor, particularly in cases where there is a tendency toward a heart condition or a heart trouble. It is well with the young, growing children not to put them strictly in the linen or cottonwares, but those who have the least tendency toward uninvolved of their heart, their kidneys, or who are sub-standard in type, need to wear at all times of the year an underclothing that has at least a little wool, so that they will not have those superficial chillings of the body that throw too much tension upon their arterial system and too much tax on their heart, and in that way lead perhaps to further trouble. The sedentary habits of the average boy, and I might say the average boy's doctor means more in the production of heart trouble than almost any other thing, aside from the diet. The average doctor has a tendency to sit too much in his office, to ride too much in his car; he becomes flabby and the cardiac muscles do not keep pace with him, and in a very short time he is suffering from cardiac muscular troubles and sometimes from a cardiac lesion. This same thing applies to other professional and business men. The prevention and cure of a condition of that kind is obvious. All of us take too little exercise, and do too little to keep our heart muscles in good condition. If we did more walking and more systematic exercising, more golfing, rowing and athletics of various types, we would all be more healthy and have less of heart disease. Dr. Ewing wisely stressed the psychic element connected with heart disease. The tendency of the average young man is to become alarmed when he finds that he has trouble with his heart. He magnifies the trouble. If his doctor will only sit down and take time to talk to the young man and make him understand that he is not doomed to a life of invalidism, he will have won the confidence of that boy and give him confidence in himself, and the result will be that he will do what the doctor wants him to do—he will worry less about himself, have less trouble and probably throw off his heart trouble entirely. Don't frighten your patients to death! There is many a young man who has

entered college with a slight heart murmur and has lived as an active citizen throughout his entire life of very many years, carrying the same heart lesion until he reaches 60, 70 or 80 years of age and yet doing good work. Don't condemn your heart case to a life of invalidism, don't condemn him to a series of pills and medications throughout his entire life. Study carefully the case, if it needs medication, give it. If the case is reaching a stage of decomposition, you have your digitalis and other remedies that you can depend upon to help in those cases; but let every case have your study and best care, don't over-medicate it; give it hygienic treatment, dietetic and psychic treatment, order proper exercise and in the average cardiac case, you will be able to benefit your patient and probably prevent development of worse lesions, resulting in early death.

Dr. Charles W. Crankshaw, Newark: I agree with Dr. Stewart that we have enjoyed Dr. Ewing's paper and thank him for the many valuable suggestions he has given us. I wish to add a word concerning the work of the Prudential Infirmary, of which I am the physician in charge and where we have over five thousand people under supervision. My associate and I have often been astounded at some of the young people who have had no idea that they had any cardiac trouble. We have followed the same line advocated by Dr. Stewart in caring for those cases—never alarming them. I have had young women and young men that I have carefully examined and then have asked them: "Have you ever had shortness of breath?" Do you complain on going up-stairs or after a little running; has your family physician examined you and called attention to unhealthy condition of your chest? Or have you ever had reason to believe you had any disturbance in your heart action?" They said "no." I say to them, "Now don't be at all alarmed; there is a slight heart trouble, just in its incipency, but you may live longer than anybody around you, but never pick up a grip and run for a trolley or train; never run up-stairs; never do anything in a hurry. Take your time and you may live long and be a very useful citizen." You will find that such people are always willing to listen to your suggestions, and if you get cases in their incipency, it is like getting the incipient tubercular cases. I remember that when I was a student, Dr. William Pepper spoke about always warning nurses and those in charge of cases of scarlet fever and diphtheria to be careful in these matters in dealing with children. It certainly applies in heart disease. Watch all your cases carefully; don't alarm them, give them proper advice in regard to exercise. I always warn against the excessive use of exercise in athletics where too many young boys and girls at the expense of their cardiac muscles in their determination to win, lose health and often life itself.

Dr. Ewing, closing the discussion—I have enjoyed the discussion of the paper very much and thank both gentlemen for emphasizing so ably the points I thought worthy of emphasis in my paper. If I simply called your attention to a condition that is a tremendous menace and enlisted your interest in its control in your own towns and cities, I will feel

abundantly repaid for the thought and time given in the paper's preparation.

OPERATIVE REDUCTION OF FRACTURES OF THE FEMUR*

Robert E. Soule, M.D., F.A.C.S.

Newark, N. J.

The object of this paper is to place before the members of this organization the treatment of fractures of the femur, taking up particularly the operative reduction, and to offer a technic, which in the writer's experience offers advantages over present methods, especially in oblique fractures.

Surgeons are gradually coming to realize that the methods advocated for years past in the textbooks on fractures no longer fulfill the present day requirements of anatomical and functional restoration. With the advancement of surgical knowledge and skill we are securing more accuracy, definiteness and certainty of correction of the disabilities formerly and even now too frequently encountered, the object being to restore the worker to his maximum of wage earning in the minimum of time.

Prior to the introduction of the buried metal splints or plates advocated by Lane and for a number of years very extensively employed in mending fractures no general advocacy of operative reduction and fixation of fractures was adopted. The timidity in cutting down on a fracture was general, and well it might be as without a competent understanding of the mechanics involved the results can be anything but satisfactory. Successful bone surgery necessitates an exacting regime of technic, as we are dealing with the passive framework as well as with the functional structure of the anatomy. With the reported results of Lane and the successful instances of cases examined a great change in the treatment of fractures was inaugurated until time and further experience revealed that what at first seemed a revolution in fracture treatment had a setback. There were infections, non-unions and malunion still occurring, despite the utmost care in observing the necessary technic. These plates had to be removed as soon as their primal object had been accomplished, that of holding the fragments

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together until callous had formed cementing them to insure union.

The same is true of all foreign material or non-absorbable material introduced into the body. If it is not removed harm can result, whether we use wire, clamps, Parham's bands, metal nails, bolts or screws, or any of their modifications. Though there are successes with the various devices there are failures too and a second operation in most instances become necessary. To subject our patients to the risk of one anesthesia with the knowledge that a second experience is ahead of him is a serious matter for consideration. The double risk has caused us to search for a means for its elimination. For the past decade, and longer, a great deal of practical work in bone surgery has been done both here and abroad, which does away with the necessity of introducing any foreign material, producing far better results than were possible before. We have even found that the patient himself possesses all the necessary material for the repair of bone as from some easily accessible part of his skeleton a segment can be transferred and implanted to make up almost any deficiency encountered, and for suture material we have the perfectly satisfactory kangaroo tendon as it is prepared today.

In the treatment of fractures therefore the surgeon must be of an open mind toward closed and operative methods, to enable him to select the best technic for the case in hand. It has been very clearly demonstrated in the investigation made by the Surgical Section of the British Medical Association in their recorded analysis of 2,900 cases of fractures that taking all cases together the operative methods have produced a greater percentage of good results than the non-operative in the bad cases.

When Hartley and Kenyon devised the sterilizeable shell for the electric motor they placed at the surgeon's hand all the power necessary to cut and shape bone with speed and precision, thus eliminating the slowness, inaccuracy and trauma of the mallet and chisel. When George Hawley placed his fracture table at the service of the surgeon he furnished an apparatus for traction and fixation, which is at the same time an operating table, which no modern operating room can do without. Both of these devices have done

much to aid in making bone surgery more definite and exact.

There have also been advances made in devices for the closed treatment of fractures but as this paper is to deal with the operative side, and as time does not permit of treating this subject in its entirety, I shall confine the rest of my remarks to the subject of the open treatment of fracture of the femur.

Now as to the selection of cases for open reduction. It is not necessary to rush into an open reduction. A week or ten days may be allowed to elapse as there may be complications such as abrasions or trauma of the soft parts which would render it unwise to immediately open a fracture. It also goes without saying that not all fractures of the femur require open reduction as many of them can be reduced and held by closed methods, but the open method is applicable, preferable and gives the most satisfactory results in certain fractures of the neck, upper third, fracture of the shaft, fractures near the knee joint where there are interposed soft tissues or imperfect extension and inability to hold fragments in good alignment, also in non-union and mal-union of fragments.

In the selection of the operative technic the operator is governed by the type of fracture he has encountered. He should adopt that method which necessitates the least trauma to the soft or hard parts and should eliminate the use of foreign material. The introduction of the intermedullary peg (either bone or ivory) necessitates considerable trauma and manipulation of the fragment as the fractured ends must be forced out of the operative wound and it is not easy to get the intermedullary dowel to fit nicely and equally into both fragments so as to hold the fragments of the femoral shaft together. In instances of a more or less transverse fracture with jagged ends, these ends can be made to lock together, frequently requiring no other fixation than muscle retraction and an adequate external splint (plaster of Paris long spica), or, I have secured the transverse area by drilling through each fragment end and tying these tightly together with heavy kangaroo tendon.

In oblique fractures of the shaft the bone nail, used according to the author's technic, is preferable as it eliminates unnecessary trauma to both the bone and the soft parts, and materially shortens

the time of operation. In these oblique fractures the greatest difficulties encountered heretofore have been in overcoming and maintaining correction and angulation and the shortening from overriding of the fragments. This type of fracture of the femur has been a most difficult fracture to rectify without some shortening but by the author's method of bone nailing all possibility of recurrence of shortening and angulation is eliminated. In the oblique fractures to which it is particularly adaptable its simplicity of application and certainty of fixation places it, in the writer's estimation, above all other grafting methods.

Details of the Technic of Bone Nailing in Oblique Fractures.

The patient is properly fixed on the Hawley table. Under an anaesthetic sufficient extension on the limbs is made to bring them equal if the fracture is un-united, and, if the fracture is mal-united, the mal-union is divided and the fragment ends freshened.

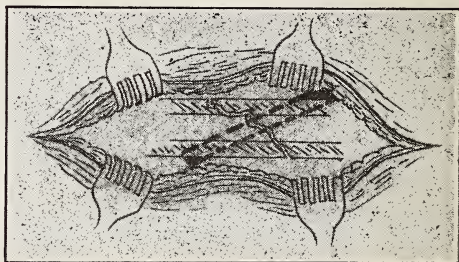
With a bone clamp the fragments are held securely in contact; then the author's long motor drill of suitable diameter is driven through both fragments at an acute angle to the plane of the fracture, as per the illustrative diagram, the diameter of the drill used being $\frac{1}{4}$ to $\frac{3}{8}$ of an inch. The motor is disengaged from the drill, which is left in situ while a segment of bone is removed from the shaft of the tibia, preferably of the same side, and shaped to fit the hole drilled in the fragments. The drill is then withdrawn and the autogenous bone nail is substituted. The separated split muscles are allowed to fall back into place, the overlying fascia is closed by continuous catgut suture, also the skin wound. A drain of two or three strands of plain catgut knotted at one end is introduced through the skin and muscle wound down to the fracture as a vent for whatever seepage may occur from the operated field. The skin wound on the tibia is closed by a continuous catgut suture, no drain. Alcohol dressings are applied to both wounds and sterile dressings over all, followed by a spiral of flannel bandage as a lining to the long plaster of Paris spica, (which is the fixation dressing of choice) from the toes to the ribs, which is removed after six to eight weeks.

At the expiration of 6 to 8 weeks the plaster is removed and baking, massage and exercise of muscles and joints begun

and the patient is allowed up with a Thomas caliper splint applied as a precautionary support to be worn from four to six months.

Advantages of the Operation.

1. The recognized advantage of using autogenous bone as a fixation material.
2. The direction of the insertion of the bone nail at an acute angle opposite to the plane of fracture insures prevention of the fragments separating and the recurrence of shortening.
3. The simplicity of the technic and the elimination of all unnecessary bone or tissue trauma, as compared with the inlay method, where usually besides cutting the gutter in both fragments to receive the graft the fragments have to be drilled to receive the graft retention sutures, whereas with the bone nailing but one hole is drilled and the autogenous bone nail inserted and no retention sutures are required, the angle of the bone nail, together with the muscle retraction binding the fragments tightly together.



Diagrammatic illustration of oblique fracture of a bone with autogenous bone nail inserted.

Four Case Reports With Illustrations Are Appended.

1. T. H., age 12 years, long oblique fracture left femur, mid-third, with $1\frac{1}{2}$ inches shortening, as a result of an automobile accident September 16, 1921. Traction fixation by Thomas splint and adhesive straps applied. Forced extension on Hawley table and operated December 1, 1921, and bone nailing of fragments by author's technic and a long plaster of Paris spica fixation.

Cast removed January 12, 1922, and physio-therapy begun.

January 18, 1922—Patient out of bed in wheel chair.

January 26, 1922—Up on crutches having baking, massage and exercise of lower left limb.

Full function restored. Aligment perfect.

2. H. S., age 11 years, mal-united fracture, lower third, left femur, with

1¾ inches shortening as a result of an automobile accident May 12, 1922. May 20, 1922, operation by traction on Hawley table and author's bone nailing technic applied. Limb fixed in full extension by a long plaster of Paris spica.

July 6, 1922, spica removed, shortening reduced to ½ inch. Union firm, skin wound healed.

July 11, 1922—Patient standing.

September 12, 1922—Discharged from hospital ward. Voluntary flexion of left knee to an angle less than a right angle, full voluntary extension of limb with increasing arc of motion at knee joint.

3. C. F., age 48, double fracture of the right femur was produced in the middle third of the shaft as the result of an automobile accident, the lower fracture about 6 inches below the upper fracture with the lower fracture in good position. The upper fracture was overlapping, oblique and irregular. A Thomas splint with traction straps was applied as the patient was rebellious and refused operation. On August 24, 1922, he finally consented to operation when with traction fixation on the Hawley table the upper fracture was reduced and nailed by the author's technic.

October 4, 1922, the spica was removed and x-ray showed fragments united in good alignment.

October 5, 1922—Patient became unruly and moving about in bed broke the pin and caused a notable angulation in the thigh, which was confirmed by a second x-ray. He was placed in a plaster of Paris long spica on the Hawley table.

December 19, 1922—Discharged wearing a Thomas caliper splint. Voluntary flexion of the knee joint about 45 degrees. Good strong union. Motion 90 degrees in flexion from full extension. No shortening.

4. J. J., 10 years old, September 1, 1922, sustained oblique fracture of the mid-third right femur as the result of an automobile accident with marked shortening.

September 12, 1922—Operation bone nailing, author's technic.

November 13, 1922—Cast removed.

November 27, 1922—Patient out of bed in wheel chair.

December 9, 1922—Discharged from hospital cured but wearing a Thomas caliper splint as a precaution against bowing. No shortening or angulation and perfect function.

DISCUSSION.

Dr. John P. Reilly, Elizabeth: Mr. President and Fellow Doctors—It is with pleasure I enter upon the discussion of this paper. I feel that today there is another step forward in the history of medicine, with the bone-peg or absorbable suture as applied by Dr. Soule. I have watched Dr. Soule's work for some time and feel satisfied as a working proposition of a hospital we have something to offer the public that is a good safe method. Strange to say we all interested ourselves for years and never were contented with the surgery of the soft parts, after the asepsis of surgery was established, until we had absorbable material to sew the soft parts with. Year after year, you remember, at the American Medical meetings, Dr. Marcy of Boston came on with another step forward, and whenever we traveled, we sought to find a better method, until success was reached in absorbable sutures for the soft parts. Why absorbable sutures for bone surgery was so long neglected, I do not know, except that it was a harder proposition and perhaps that accounts for it. Those of us who traveled the road in the early days of hardship with bad results, unsatisfactory cases after our efforts, the best that we had at the time—welcomed Lane's proposition, but we welcome it, of course, only to be dissatisfied with it in so many cases that we became discouraged. Then along came the bone inlay, which was one of the best steps forward in bone suturing. The peg, I believe, in certain cases, is filling a want that will never be improved upon. I feel that it is the final word for a certain class of cases. The reason that I am intensely interested in the subject, however is this: If you are interested in an institution and in what you have to offer the public and what you are handing out to your that will be acceptable. There is something in vogue now which the average practitioner fellow man, you will want to give him results does not like, and that is the rehabilitation clinic—and, gentlemen, it is your own fault and my fault. We stood by institutions and men doing work who were satisfied to turn that work out that the public would not stand for; that the insurance companies that had to foot the bill of the long morbidity, would not stand for, and that the attorney, ever willing to look for a proposition for business, would not stand for. Therefore, they began to look around for means to pick up the work where the doctor left off, apparently as the best that he could do—or he should not have left it off. The war brought on vastly improved methods of leaving injured bones in a more workable condition, and too many institutions, too many physicians neglected to grasp the opportunity. But these people, alive to the business side of it, began to feel that here was a field that had to be helped along. You and your staffs could not do it alone in your hospitals; it is an expensive proposition; you have to go to your board of managers; you have to educate them, which is not always an easy matter. But I have failed to find the board of managers which, if the proposition is put up to them wholeheartedly and in an intelligent way and they are shown that if they are going to offer to the public something, they have to offer the best, will not say, "All right, do your part and we will do ours." Did you do your part?

That is why I am backing Dr. Soule, and that is why I dropped out of this work myself and left it to a man who is devoting his life to it. Nearly every other department of medicine and surgery was taken up and relegated to the specialist. Every man, however, hung on to his bone case, never minding the result. We said to the board of managers of our institutions, "We have got to turn this work out in a suitable manner to the public; something that we can stand back of. Let private cases be handled as they like, but the cases that are in the public ward must be handled the best." I further told my board of managers this, and I won them: "It is only a man who in my judgment is thinking of bone surgery alone who can do it right."

Dr. George H. Sexsmith, Bayonne: I was much pleased to hear Dr. Soule be so moderate in his claims for operations. I came rather prepared to hear him talk along the line of operation anyway. That is what we hear so much of. Some few years ago I did three operations in bone surgery, where I do one today, feeling that I could not get the results that I wished unless I did. I find in the doctor's paper that he is very moderate in his claim as to the necessity of operation; that he is very careful in his choice of cases; that he does not operate on all sorts of fractures. So far as discussing this plan of procedure is concerned, it is hardly possible to discuss it any more than to say that it is ideal in the oblique fracture. This plan of procedure of ligaturing transverse fractures of children with the kangaroo tendon, I have followed out for some time with splendid results. I will just speak of one case, during the autogenous graft in the oblique fracture, to prove the efficiency of the autogenous graft or retaining appliance over the forearm. It was a T-fracture at the lower end of the humerus. It is the only one that I recall, where I have used the autogenous graft or pin in such a fracture. It was necessary to have it come on both sides, to hold; the condyles had been split apart; the upper fragment was diagonal or oblique from both directions. I had two pins prepared; put one pin into place; dropped the other one. There was nothing to do about it: The patient was not in a very good condition and was not a very good operating risk, and I dropped a nail into the other one. From the x-ray findings, there was perfect apposition. But what was the result? Before I had gotten four weeks along, I had to remove my nail. I had gotten good results; but I did not have to remove the autogenous graft, showing in this one single case what was brought out by the discussion of Dr. Reilly when he told how he had to get away from the foreign substance. I have had this experience, and I am through using the plates, the nails, the bands, and I am through using them because I had trouble with septic conditions resulting therefrom, and in some cases if I didn't have septic troubles, they became troublesome and a second operation was required.

In the treatment of other than oblique fractures of the femur, I have used the autogenous graft, always taking the graft from some other bone. In many cases, the same graft has been used, taken from the two fragments, making one much longer than the other, and sliding it over the space, but you have lost so much

bone in formation or in the sawing of the parts that it is almost necessary, if you want a tight fit or something that will retain your fragments in that position, to take your graft, widening the space between your twin-saws from some other part of the body, from some other bone. As to the amount of shortening allowable, I recall a few years ago talking to a physician surgeon who was in charge of a case, and he had an inch and a half shortening, but good, solid bone, and this surgeon said to me earnestly, "But what is the difference: that man walks all right? He only has an inch and a half shortening." I said, "Why are you satisfied with that?" He replied, "Well, what difference will it make to him? He is about twenty-four years old; he works; his joints are all right; he walks all right; he has a little limp, but that will be all right." I said, "Suppose that were in your own family: Some surgeon had charge of it and that member of your family came out with a limp caused by a shortening of an inch and a half?" You may escape suit in such a case, but should you do a thing like that? The doctor spoke of half an inch allowed. Well, I believe you can get away with anything less than an inch in court, and three-quarters of an inch is not considered bad. The reason I bring up this point is along the line of what I want to speak of a little later, and I will bring it in at just this point; that is, we do not take seriously, the disabilities resulting from our treatment of fractures. Dr. Reilly stole some of my thunder, but he did it well, when he touched on that particular part of the subject. Taking out an appendix is just a joke for any ordinary assistant surgeon. The house staff, after a man has been in a hospital eighteen months, will take out an appendix all right; but what do the men in their general practice do with their cases of appendicitis? They turn them over to the surgeon. It is a mere joke to take out an appendix, compared with operating on the type of cases that we saw on the screen here today.

There are a few important points that I just want to touch upon. One of them was the one I have just been thinking about: First, how much shortening is allowable? The doctor puts it at half an inch. I always say, "Well, if I do not get more than three-quarters, if the patient goes out with not more than three-quarters, I feel comparatively safe and satisfied." That amount will give no disability, if you have good union, and a very slight limp. We touched upon the second, which was: Should we use the foreign substance in any case where we know the dangers of sepsis? Should we at any time use them? You hear men say, "Well, I have used the wire, I have used the nail, and I have gotten very, very good results. Once in a while I get a little pus." Should you do that, when you can use what we have heard presented today? Have we any right to? Then third, As I have touched upon before: Does the profession consider as seriously as it should, the disability resulting from fractures in general? Is there any other line of surgery where our failures are so evident as in this particular line? Is there any other line of practice where the general practitioner, the ordinary practitioner will undertake anything so difficult as a fracture of the humerus? But the general practitioner will have x-ray pictures taken and

will cling to the case with a peculiar tenacity—I sometimes wonder why. There is not much money in it. It is the poorest line of practice, so far as pay is concerned, for the amount of work involved, that there is. The doctor knows that. Perhaps he is growing rich because there is so much of it, but for the amount of work done, there is no line of practice that pays so poorly. I don't know that I have anything more to say except that I wanted to touch upon the matter of the Hawley table. I want to say to the doctor that if he gets an Albee table, he will feel as if he wants to exchange his for an Albee table; he will feel that is his money well spent. I tried the Hawley table, but I found that on account of inability to get traction when the legs were separated, in putting in the pins in the cases of fracture of the neck of the femur, you lost all your extension when you once separated the legs, on account of the conditions at the center pin.

Dr. Clarence L. Andrews, Atlantic City: I am very sorry I did not hear all of the paper by Dr. Soule, but I was much interested in what I did hear of it. In 1913 I gave a good deal of attention to surgery, though I do little in that line now. I was associated with Dr. Hugh H. Stout of Virginia, a protege of Dr. Finney of Baltimore, and we became very much interested in this problem. Prior to that some English doctor had been trying to determine whether there was any advantage in using an absorbable plug as compared to one of non-absorption. So a very small motor was devised, and, as I recall, a very similar little contrivance to this, by which he could cut a peg, and by a second contrivance he could bore the hole. We did quite a number of these operations. They were extremely successful, and if you did not get infection, of course there was practically primary union. I recall one particular case of a child about four or five years old, with spine bifida, and, as you know, that is a very difficult thing to handle. The child was absolutely in a state that it never could be forth anything. Along with this contrivance for boring out these pegs, he evolved two little saws that ran so close together that you could take off a strip of bone just in the same way that you would veneer a piece of furniture. The child was anesthetized and was all ready and when he got down to the point of operation he took this small contrivance and after he removed the periosteum, he took a very thin layer of this bone from the front of the tibia, transplanted it to this child's back, used some of the very small pegs and cat-gut sutures, and the child, strange to say, recovered. That is, I believe, one of the few cases of spine bifida of that type that has been reported at that time. This case was reported in the Virginia Medical Journal and I believe in the A. M. A. Journal, either 1913 or 1914. I have seen Dr. Stout since that time and he is very enthusiastic over this method. The next thing that came up, that we were interested in, was as to whether you got by this graft or implant, regeneration and then degeneration of a bone. That is something we never definitely decided, but we came to the conclusion that this graft was not absorbed in too, but that there was a process of taking it away, so to speak, and then a re-deposition of new bone. I won't quote that as being altogether authentic as I am a little

rusty on the findings, inasmuch as it has been ten years ago; but we felt there was not an exact growth of that bone in the sense that you transplant a twig and expect it to grow.

Dr. Edgar Holden, Newark: Probably most of us do not realize how much we owe to Dr. Soule in the matter of developing the bone plate, not only in this line but also in his flat foot operation. It is really splendid to note the results there in betting autogenous material to the point where you have a good union. He brought out the fact that occasionally one can get a good union with the kangaroo tendon thrown around. I think it is very important to bear that in mind because where a patient is in a rather poor condition, you do not want to take time enough to open up the tibia and subject the patient to the extra shock of that secondary operation. There is another possibility, too, that we ought to bear in mind; namely, that occasionally if the operation has to be rather rapid on account of the patient, and the kangaroo tendon would not do, we have at our disposal the commercial bone plates, which are perhaps an inch and a quarter to an inch and a half long, and if thoroughly sterilized, cause no trouble. I have used a great many of them and have never had trouble from them. In that way you can drill the hole quickly and throw in a commercial peg and then suture up the wound. Of course, it is not as good as the autogenous. There is another feature that many of us do not realize; namely in the first place, that with children there is a very strong tendency to bone formation if the leg is held properly, even if there is a muscle plate in between. If you get a good line up and possibly a slight separation from muscle fibre, every once in a while it is well to wait and see whether that child won't get up a union. I recently had one that surprised me. It was an old lady seventy-six years old; very fat, with a bad heart, in very bad condition. She fell and injured her arm and went for twenty-four hours with a long, spiral fracture here, with no retention at all. The arm was black from her shoulder to the finger tips, from ankylosis, and I put her up in a traction splint and got an x-ray, and it was in good condition; that is, I pulled it down, but with some rotation of the spiral. The next night she took the splint off and slept without it, and her arm was worse yet. I put it back on; she took it off again. Then I took her down to the hospital and put traction; put her up in plaster spica around the shoulder and to the finger tips. Then I had another x-ray taken and found I had overcome the rotation. The fragments were directly opposite but there was three-eighths of an inch separation of muscle in between. Then I made a window above and below and tried to push them together, and I put heavy felt pads in. I did not want to operate on the woman because I did not think she would come off the table. Then I had another x-ray taken with these pressure pads on and there was still three-eighths inch space between the muscle plate. I kept her up for two weeks and then I felt of it and there seemed to be union. I kept her on it for five weeks and I found she had union. How she got union between those muscle plates I do not know. I am going to hold it there longer; but at the same time she had union in that humerus.

I do not know how that happened, but sometimes the unexpected does happen. If the leg has been mobilized, we notice in the x-ray there is a marked decalcification in all cases. If a sliding graft is made there, you have devitalized bone, and it is far better to take your graft from the tibia, say where the bone is in better condition and you have a stronger graft and a better chance for a good result. Personally I do not think there is any way to immobilize an imperative fracture case, except with plaster, because in spite of everything, if you have splints of any kind on, the patient can displace the splints, whereas if you put them up in a spica cast after x-ray and you have a good position, you have got them, as long as that plaster spica does not break, they cannot get away from it and they can't spoil your operation. I want to say again that I think Dr. Soule deserves a tremendous amount of credit for bringing out that bone peg; I think it is wonderful in all cases where you want to get two bones to grow together or two fragments of bone to grow together.

Dr. Frank W. Pinneo, Newark: Dr Soule has brought out some very excellent points, on this matter of bone and joint surgery, which might be said to be the inheritor of orthopedic surgery in term; so much so that overseas in Sir Robert Jones' Division, which was an orthopedic division, before the war ended they came to call it a Division of Bone and Joint Surgery. The progress that this bone and joint surgery made in the war was one of the outstanding things in the World War, for neither in bacteriology nor in any other branches of surgery and medicine was there more progress made than in this. I have suggested this analogy for the combination of two things that we have always struggled with; namely, the initial injury and the preventing of ultimate deformity. You have two eyes and you can see very well with only one eye. Looking through that one eye, you get a flat picture. You could not get along without that one eye. Close that eye and use the other, and you still have a flat picture, and it is useful. But you see the value of the parallax of the two eyes. Surgery is the vision of one eye—indispensable. Orthopedics, or we will say the prevention of deformities is the vision with the other eye. Now, in a fresh fracture, if the one who falls into the responsibility of caring for it first can get that parallax, the relation of distance, can do the surgery, fight the infection, save the life, but not be satisfied with that and leave unnecessary deformity to fight afterwards and can prevent deformity, can get bone union, can get joint function at the same time that he is fighting the infection, he has just what we are striving for: The combination of all that is in the interest of the patient applied at the same time. You get the parallax of the two eyes; you apply the surgery and you apply the prevention of deformity. In the compound fractures that the war was so fraught with, one of the great advances was this extension in suspension, with the Balkan frame. What Dr. Soule has shown us this morning does not apply to just that group of cases, and his argument for the splendid bone peg work and other operative work that he has shown may apply to other cases or to cases in which the first treatment may have failed of perfect re-

sult. This improvement in the use of absorbable sutures or absorbable material (the autogenous bone being the ideal probably) is one of the advances that we have made. I think we can thank Dr. Soule and we can also approve all that has been said of the outstanding importance of realizing the importance of bone and joint injuries at the start. If this is appreciated, you will prevent another group of deformities which I have suggested calling secondary deformities. There is no need of having a stiff elbow or a stiff ankle or a deformed arm simply from a fractured humerus or a fractured femur. Prevent the secondary deformities.

Dr. Alexander MacAlister, Camden: I would like to ask Dr. Soule how long he has been doing this bone-peg work, and if he has ever had any cases in which the peg has exfoliated afterwards? In my years of practice I have had quite a few cases where the Lane plate had been used in the majority of them, sometimes two and three years, and I had a case recently where a Lane plate was put in about fifteen years ago and it had to be removed.

Dr. William C. Westcott, Atlantic City: I would like to ask the doctor if there is any law as to how much we might permit, so far as shortage is concerned, and still not be held responsible?

Dr. Soule, closing the discussion: The doctor has asked how long I have been using the bone-pin or nail. It is nearly fifteen years since I began using it. It only is recently, however, that I have had an opportunity of using it very extensively in fracture work. I do not think there is any law governing the amount of shortening, but I think there is a general understanding that we are all governed by, in expecting to get away with a certain amount of deformity. We can expect our colleagues to help us out, and the less the shortening the more support we can have in fighting our cases. I understand there have been several decisions where three-quarters of an inch have passed the judge's question of approval.

SOME PHASES OF CARDIAC PATHOLOGY.*

By A. V. St. George, M.D.,

The object of this paper is not to present anything strikingly new or original, but merely to correlate more clearly our conception of some diseased hearts. Clinically, certain terms are used which convey to the auditor an entirely different impression from that really intended. Thus, chronic interstitial myocarditis, chronic fibrous myocarditis, fatty degeneration of the myocardium, etc., are terms which require some qualification. To appreciate these conditions, let us first refer to some general etiological considerations. Lesions of the heart are incurred (1) as infective inva-

*Presented at the staff meeting, Jersey City Hospital, March 8, 1923.

ions of the endocardium, myocardium and pericardium, and their secondary effects; (2) lesions secondary to blood vessel disease (degenerative processes); (3) lesions secondary to changes in the streaming blood; (4) tumors.

Many pathologists have observed that there appears to be an increase in the fat content of the heart, particularly in the region of the right anterior epicardium. Recently Gross, working with Oertel, demonstrated by means of an injection method in a series of hearts, the relative changes between the blood supply of the right and left heart with each decade, this being part of the work of a more extensive problem on organo-genesis and organ change. He showed that the blood vessels became more prominent in the left heart and proportionately less in the right heart. His work is extremely valuable and can explain some of the clinical phenomena, notably ventricular preponderance in the electrocardiogram. On the other hand, Thorel emphasizes the fact that, at autopsy, fat is found so frequently without disturbances during life, that fatty degeneration of the heart muscle fibres is not of great importance. Master examined a series of thirteen hearts obtained in the Bellevue morgue, from cases of accidental death, in which considerable fat was found in the muscle at all ages. He emphasizes that fatty degeneration of the heart muscle should be diagnosed only microscopically. Fatty infiltration or fatty degeneration of the heart muscle as such is probably not as common as is generally diagnosed or reported at autopsy. There is, however, a condition of cell atrophy and fat deposition (infiltration), particularly in the region of the right ventricle, which can be demonstrated in any moderate autopsy service. This condition can be readily explained on the basis of the blood supply, if we bear Gross' work and that of some of the older investigators in mind. It has been observed that the fat is deposited first in areas farthest from the supply of blood to the part. Whether this fat is derived from the cells themselves or represents fat brought to the area and the inability of the cells to metabolize it, remains a disputed point. The former theory appears the more tenable, except for the fact that there is very little microscopic evidence in the cells.

Pathologically, such hearts show a fatty deposit over the entire right ventricle and extending in between the muscle fibres, replacing them to a greater or less extent.

On opening the heart, the fatty invasion presents a typical tooth-like appearance. The subjects of this affliction are usually advanced in years, suffering from senility and general atrophy of the body, and the clinical manifestations of such hearts may be variegated indeed, ranging from no symptoms whatever to those of a most intense type of dyspnoea, bradycardia, tachycardia, irregularity, etc., ending in gradual death from myocardial incompetency (a true myocardial insufficiency). Kolisko states that many of these individuals die suddenly from rupture of the heart. However, in the autopsy service of Bellevue Hospital and that of the Chief Medical Examiner of the City of New York for the last five years, no such case ending in rupture was encountered. It is somewhat difficult accurately to classify this type of death. The process affecting the heart is but part of a general senile process, and though the actual cause of death may be in the inability of the heart to perform its function, nevertheless a certificate of myocardial insufficiency without some other etiological qualification, is not accepted by registrars of vital statistics. Hence, the terms fatty degeneration, chronic myocarditis, etc., are introduced, when in reality the patient has no such condition and the physician in attendance is well aware of the fact. It would probably be more nearly correct to classify these patients as general senility (or atrophy) with myocardial incompetency (primary).

Chronic fibrous myocarditis or chronic interstitial myocarditis are terms used rather loosely with many heart patients. Chronic fibrous myocarditis or chronic interstitial myocarditis is a *diffuse* process attacking all or nearly all of the heart muscle. It follows certain of the severe infections—diphtheria primarily, and, to a less extent, syphilis, typhoid and other infections—and is a relatively rare lesion, probably becoming more so due to the gradual diminution in the etiological factors. It is due to a direct action of the infecting organism or its toxins upon the heart muscle, causing degenerative inflammatory changes, ending in fibrous tissue replacement. Chronic fibrous myocarditis can occur in individuals at any age and presents an extensive variety of symptoms, depending upon the site of the principal focus. Thus, involvement of the conduction system may give rise to any number of clinical pictures. Its presence is cause for apprehension, and many of these patients cannot be given a good prognosis.

Localized fibrous myocarditis (cardiac infarction). This clinical condition is primarily a blood vessel disease produced by thrombosis of a coronary branch with subsequent infarction, myomalacia, and rupture of the heart muscle. Certain factors in this picture must be borne in mind; namely, that it is a disease occurring usually in persons advanced in life, usually in males, in whom an arterio-sclerotic process has invaded the coronary vessels. In all statistics and in our own observations in the Bellevue autopsy service, the vessel generally affected is the first anterior descending ramus of the left coronary artery, or a branch of it. Hence the site of the tear is usually in the anterior wall of the left ventricle. The lesion may have involved a goodly portion of the ventricular wall or only a small part. The tear is usually not more than 2 to 4 cm. in length, markedly irregular and ragged. Coronary thrombosis is but little understood clinically. Most text-books of medicine associate the lesion with sudden or almost sudden death. Although it is admitted that death may be more or less instantaneous, nevertheless a large proportion of the cases have their life prolonged for a period of hours, weeks, months and rarely even years. The blood supply to the heart here, again, plays an important role. Gross has shown that there is a fairly rich anastomosis between the ramifications of the right and left coronary vessels, and unquestionably the extent of these anastomoses, together with the size of the vessel involved, determines whether or not death shall be immediate. Clinically, these cases present an extremely interesting picture which often goes unrecognized. The patient may have had some subjective cardiac distress, but the striking picture comes suddenly, usually after some exertion. The patient complains of more or less intense precordial pain, simulating an anginal attack, with cold perspiration, faintness, and even an accompanying collapse. He may die in such an attack. Some, however, after a variable period, recover from this attack and gradually resumes his or her accustomed occupation with only little cardiac distress, which, however, is more or less constant, and thus serves to differentiate it from true angina pectoris. This interval may be for a period of a few days or many months or even one or two years. He may then be seized again with a similar attack, more intense than the preceding one, which does not respond well to the administration of morphine, and the patient usually dies after a period of sev-

eral hours. During this time he complains of intense precordial pain radiating down the arm, into the back or even to the right side—in other words, a severe angina pectoris. His skin becomes cold and clammy; cyanosis develops and marked anxiety is present. The pulse is irregular and rapid, and gradually becomes less perceptible. The length of time with which a patient may continue in an attack is undoubtedly determined by the size of the tear and the facility with which the blood is expelled through it. Death results not so much from loss of blood as from actual tamponade of the heart by the blood pumped into the pericardial sac.

The lesion of coronary thrombosis with infarction and localized myocarditis is very much more frequent than text-book statements admit. Recently, nineteen cases were reported by Wearn and, in a period of almost six months, four cases were encountered in the post-mortem service of the Bellevue Morgue. Its recognition before death is suggested by a history of previous attack followed by a period in which there is more or less constant cardiac sensitiveness, ending in a sudden severe anginal attack with death. Pardee and Wearn, in recent papers, indicate that coronary thrombosis can be diagnosed with the aid of the electrocardiograph.

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Clinical Reports.

Actinomycosis of the Gum.—Dr. Adolf Erdos of Nagyvarad relates a case of actinomycosis in a girl from a prick with a straw between the first and second molar teeth. The gum bled for a few minutes and the wound healed rapidly, but five weeks later a hard, painless swelling, about the size of a walnut had formed over the site of the wound. After nine months it was extirpated and found to be composed of fibrous tissue within the meshes of which was granulation tissue with a few drops of pus containing the ray fungus.

Middle Ear Infection in the New-Born.—Mahu and Chome report a case of otitis media in a new-born child infected during a prolonged delivery. The infection probably occurred during inspiration or a swelling move-

ment. They emphasize Renaud's findings of otitis in every one of his seventy *neropsies* in infants. They recommended instillation of a few drops of antiseptic in the nose, especially when delivery is prolonged in infected cases.

The Cure of Trachoma With Radium Rays.—L. Muller and F. Hogler (Wiener klinische Wochenschrift, December 7, 1922) report some excellent results in five cases of trachoma treated by radium. The treatment is simple and absolutely not dangerous when carried out by an experienced radiologist. It is a distinct advance over the methods used heretofore. The authors irradiate three to five times with 150 to 250 milligram-radium element hours for each dose.

Trauma and Appendicitis.—Dr. H. W. Wild, in the British Medical Journal, while visiting a patient, was requested to examine a boy belonging to the same household. Three days previously he was struck in the abdomen by a perambulator, and since then complained of violent pain. The high temperature, rapid pulse, tenderness over McBurney's point, and rigidity of the right rectus muscle gave the impression that the boy was suffering from appendicitis. Dr. Wild visited him early the following morning and found that the temperature was still high and the pulse very rapid, and in addition, the patient was doubled up with pain. He was removed to a hospital, where he was operated upon that afternoon. Laparotomy revealed a gangrenous condition of the appendix. Recovery was retarded by an attack of broncho-pneumonia, but eventually the boy left the hospital fit and well.—Critic and Guide.

Gall Bladder Disease.

Dr. Russell S. Fowler in the Long Island Med. Jour., says: In looking over the records of his operations for gall bladder disease, he finds 608 cases in which the pathology of the lesions encountered is sufficiently and definitely described to permit the division of the cases, according to the lesion, as follows:

| | Total | Recovered | Died |
|---|-------|-----------|------|
| Acute cholecystitis | 230 | 206 | 24 |
| Chronic cholecystitis | 331 | 330 | 1 |
| Acute cholecystitis and acute pancreatitis | 6 | 4 | 2 |
| Chronic cholecystitis and chronic pancreatitis | 30 | 30 | 0 |
| Carcinoma of the gall bladder or bile ducts | 26 | 15 | 11 |
| Carcinoma of the common duct and pancreas | 8 | 5 | 3 |
| Curiosities of the gall bladder—Absence of gall bladder | 1 | 1 | 0 |
| Intestinal obstruction from gall-stone | 3 | 2 | 1 |
| Syphilis of gall bladder | 1 | 1 | 0 |
| Choledochus cyst | 1 | 0 | 1 |
| Ecchinococcus disease of gall ducts | 1 | 1 | 0 |
| | 608 | 565 | 43 |

Unfortunately many medical men do not seem to grasp the necessity for an early operation in gall bladder disease, which, in view of the pathology of the disease and its proved

progressive nature, the surgeon feels he may logically request. On the contrary, many cases are sent to the surgeon when the disease has advanced to a stage where relief is possible but not complete cure. In this respect the history of appendicitis of a generation ago and of duodenal ulcer of a decade ago is being repeated. No one now thinks of any method of treatment for appendicitis other than operation, nor of treatment other than surgical for duodenal ulcer, once its chronicity is established. Yet gall bladder disease continues to be treated medically in spite of the fact of its chronic progressive nature and the well proven fact that such an infected focus is responsible for so many complications.

Sudden Death from Anaphylactic Shock.—F. W. Sumner (British Medical Journal, March 17, 1923) reports a case of sudden death within five minutes after a prophylactic dose of one thousand units of diphtheria antitoxin. This was probably a case of status lymphaticus with enlargement of the tonsils and adenoids and a persistent thymus. The patient showed an intolerance to the vicinity of horses. The horse serum is no doubt the offending factor in these cases. To avoid such accidents the author recommends a preliminary intravenous injection of 0.5 c. c. the ten per cent. diluted serum and, if no adverse symptoms arise in an hour, the subcutaneous injection of the remainder of the dose should eliminate the possibility of anaphylactic disaster; a preliminary intravenous injection of a preparation consisting of sodium carbonate five grains, gum arabic one dram, glucose one dram, in normal saline solution up to thirty c. c., together with an intramuscular injection of a sterile solution of one grain of calcium chloride dissolved in ten minims of normal saline solution an hour before the serum injection should also do away with any chance of anaphylaxis.

County Medical Societies' Reports

ATLANTIC COUNTY

Royal E. Durham, M.D., Reporter
The first fall meeting of the Atlantic County Medical Society was held at the Hotel Chalfonte on Friday evening, October 12th at 8.30 P. M. A most interesting scientific program was arranged by President Clarence L. Andrews, as follows: Dr. Guy T. Hunner of Baltimore, Md., spoke on "The Great Importance of Ureteral Stricture in Kidney Pathology," and Dr. W. F. Moore and Dr. R. M. Lukens of Philadelphia, Pa., spoke on "Pulmonary Suppurations, Their Treatment by the co-operation of the Internist, Roentgenologist Laboratory and Bronchoscopist."

Dr. Moore in his paper considered bronchiectasis and pulmonary abscesses: He said that first the internists should make a careful examination of the chest and this should be followed by an x-ray examination. Then a bronchoscopic examination should be made to determine the proper procedure as to treatment. In the bronchoscopic examination the character of the mucus membranes are noted and all obstructions and secretions are noted.

The secretions are obtained by a swab or by aspiration and sent to the laboratory where autogenous vaccines are made and given to patient once or twice weekly. The vaccines are changed every two months according to the change in the bacterial content of the secretions. If any temperature or weakness these patients are naturally kept at rest in bed. At the second bronchoscopic examination all abscess cavities are aspirated and cleansed with antiseptic solutions, using a return flow so that no fluid is retained in the lungs. Any constrictions of the lumen of a bronchus is dilated and all granulations removed. These cases are dispensary cases and hospitalization is not required for this treatment. The treatment is done under a local anesthesia only. Extensive cases of bronchiectasis respond but poorly to this treatment.

Dr. Lukens then showed slides and motion pictures illustrating the technique of the bronchoscopic treatment.

Dr. Hunner said, in part, that over 90 per cent. of cases of chronic pyelitis are due to ureteral strictures. In like manners 90 per cent. of cases of hydro-nephrosis are due to ureteral strictures. Also many cases of stone in the ureter formed in situ as well as recurrent renal calculi are due to urinary stasis secondary to ureteral strictures. Idiopathic hematuria is usually caused by undue mobility of the kidney secondary to ureteral stricture. Irritability of the bladder and neuroses of the bladder are frequently secondary to ureteral strictures. Focal infection is the underlying condition causing ureteral strictures and should be diligently looked for, in the teeth, tonsils, sinuses, middle ear, gall bladder, intestinal tract and prostate. Dr. Hunner showed many interesting slides showing catheters with wax bulbs passed through ureters with strictures and illustrated the method employed in dilatation of ureteral strictures. He also cited many cases of chronic pyelitis, hydronephroses, stone in the ureter and recurrent renal calculi cured by dilatation of ureteral strictures found in each case.

BERGEN COUNTY

Frederick S. Hallett, M.D., Reporter.

The annual meeting of the Bergen County Medical Society was held in the Golf Club rooms, October 9th., Dr. E. K. Conrad the president in the chair, with 58 members present.

A dinner to our one honorary member, Dr. John J. Haring preceded the meeting. Dr. Haring formerly resided at Tenafly and he was in actual practice there more than 60 years and was a faithful member of our society. About eight years ago he retired from practice when we gave him a dinner, and made him an honorary member of our society. He is 90 years of age, vigorous and active in mind and body. Am sorry I am unable to give his after-dinner speech.

The following officers were elected for the ensuing year: President, Dr. George L. Edwards, Bogota; vice-president, Dr. Herman Trossback, Hasbrouck Heights; secretary, Samuel T. Hubbard, Hackensack; treasurer, Dr. Wilson D. Webb, Hackensack; reporter, Dr. Fred S. Hallett, Hackensack; annual delegates to State Society, Drs. George W. Finke, R. L. Knapp, Edw. P. Essertier.

BERGEN COUNTY

Dr. Frederick S. Hallett, Reporter

The November meeting of the Bergen County Medical Society was held at the Hackensack Hospital, November 13th, 8.30 P. M. The president, Dr. G. L. Edwards in the chair. 56 members were present, the largest attendance in the history of the Society.

Dr. Reginald Sayre, New York City, was the speaker for the evening and he gave a very interesting and instructive talk on "Some of the Errors in Orthopedic Diagnosis." His points were illustrated by lantern slides.

Following Dr. Sayre, Dr. Wells P. Eagleton reviewed some of the activities of the Welfare Committee of the State Society and outlined some of the proposed work for the coming year. Dr. Eagleton's remarks were well received.

Both Dr. Sayre and Dr. Eagleton were offered a raising vote of thanks for honoring the society with their presence.

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

The annual meeting of the Gloucester County Medical Society was held Thursday afternoon, November 15th, at Hotel St. Paul, when the following officers were elected for the ensuing year:

President, Dr. Samuel F. Ashcraft, Mullica Hill; vice-president, Dr. J. Harris Underwood, Woodbury; secretary and treasurer, Dr. George E. Reading; reporter, Dr. Henry B. Diverty, Woodbury; censors, Dr. James Hunter, Jr., Westville; Dr. Cyrus B. Phillips, Pitman.

Delegates to the Medical Society of New Jersey—Dr. R. K. Hollinshed, Westville; Dr. S. F. Ashcraft, Mullica Hill; Dr. David R. Brewer, Woodbury.

Delegates to Salem County Medical Society—Dr. S. F. Ashcraft, Mullica Hill; Dr. E. E. Downs, Swedesboro; Dr. H. W. Stout, Wenonah.

Delegates to Camden County Medical Society—Dr. C. F. Fisler, Clayton; Dr. S. F. Ashcraft, Mullica Hill; Dr. James Hunter, Jr., Westville; Dr. Ruth Clement, National Park; Dr. Henry B. Diverty, Woodbury.

Delegates to Cumberland County Medical Society—Dr. C. B. Phillips, Pitman; Dr. William Brewer, Woodbury; Dr. J. Harris Underwood, Woodbury.

Delegates to Burlington County Medical Society—Dr. O. R. Wood, Paulsboro; Dr. James Hunter, Jr., Westville; Dr. David R. Brewer, Woodbury.

Delegates to Atlantic County Medical Society—Dr. James Hunter, Jr., Westville; Dr. C. B. Phillips, Pitman; Dr. Henry B. Diverty, Woodbury.

The following committees were appointed: County Tuberculosis Sanatorium—Reading, Wm. Brewer, Underwood.

Membership—Hollinshed, Downs, Lummis. County Laboratory—James Hunter, Jr., Dr. R. Brewer, Campbell.

The report of the secretary-treasurer was received and read. The secretary reported that dues to the state association have been reduced to \$5.00 a year. The Gloucester County Society has lost two members during the past year, one by death, Dr. Harry A. Stout and one removal to another State, Dr.

Dr. Wm. H. Carpenter, Aberdeen Place, Woodbury, was transferred from the Salem County to the Gloucester County Society. Dr. Robert H. Reeves, Paulsboro and Dr. Benjamin F. Buzby, of Swedesboro, were elected to membership in the society.

Among the guests present were Dr. Husted, of Woodstown, and Dr. James, of Pennsville, delegates from Salem County Medical Society. Dr. John B. Morrison, of Newark, Secretary of the State Medical Society, sent regrets of his inability to be present.

Dr. Harry A. Cotton, of the State Hospital, at Trenton, who is recognized as a world authority in his specialization in the medical world, was the speaker of the afternoon. His address was illustrated by lantern slides showing the manner of work conducted by him in the State institution. He was listened to with a great deal of interest as it was filled with information for the physicians. The subject of his address was "Sepsis in Medicine."

Dr. Cotton recently returned from a two months' trip to Europe where he was invited as a special guest and speaker by the London Medical Society to observe the work as conducted by them and in which he is especially interested.

HUDSON COUNTY

Wm. Freile, M.D., F.A.C.S., Reporter

Dr. Chas. B. Kelley called the Hudson County Medical Society to order at 9 P. M., November 8th, 1923, at the Nurses' Auditorium of the City Hospital. A synopsis of the minutes having been published in the Bulletin, the usual reading was dispensed with.

In the absence of the chairman, Dr. Cosgrove, of the Faison Memorial Committee, Dr. Quigley reported the recommendation that a building to be known as "The Academy of Medicine" be erected, and that in that edifice a room or some simple memorial be dedicated to Dr. Faison. The speaker outlined the idea of a stock issue to take care of the ground purchase and building erection. The president mentioned that this matter had been trailing along since last Spring and urged some definite action, if the project was to be at all acted on, and he mentioned some possible sites, that were available and the prices wanted therefor.

After some discussion, a motion of Dr. Pollak was carried that this be made a special matter of business at the next meeting, and that the next notice should indicate the fact.

Dr. Quigley reported with reference to the meeting called at Newark with Dr. Eagleton, to consider the present Compensation Law. There were gathered various physicians connected with the rehabilitation clinic, advising and consulting boards, men interested in industrial service, secretaries of the various county medical societies. Hudson was represented by Drs. Miner, Cosgrove, Arlitz, Dickinson and the speaker. The entire afternoon was spent on conferences. Among other things, the question of amending the act to permit injured employees to have their choice of physicians was discussed: There was much said on both sides, and the impression Dr. Quigley got was that there should be certain restrictions to protect the employee and the employer, and the narrator felt that this subject should be referred back to the county so-

cieties, for individual action before any definite action was taken.

A communication from Dr. Reed, former president of the A. M. A., regarding a publicity syndicate was referred to the committee, of which Dr. Jaffin is chairman.

Dr. Pollak spoke of the action of the "Paterson Call" which will not insert any news of malpractice suits, or other deleterious items, court for adjustment; in other words, the newspaper will not attempt to try these cases in the press. Many recent cases in this county have been in effect a trial of the affair by the press, before anything germane to the point at issue had been proven, and therefore he thought we should emulate the Paterson newspaper.

Drs. Bortone and Jaffin had discussed that afternoon the advisability of seeing the editors of the local papers. They felt that if the newspaper men were carefully approached and allowed to see the matter at the correct angle, much could be accomplished. This coming within the scope of the Publication Committee, it was referred thereto.

Dr. John Nevin, Medical Director, stated that beginning November 21, 1923, a series of clinics, under the auspices of the staff (so that there would be no criticism) would be held at the City Hospital. He enumerated the prominent men who would participate, and asked that the membership of the Hudson County Medical Society would visit them on this occasion.

Dr. Perlberg had a motion carried approving the action of Dr. Nevin.

Ten proposals for membership were passed to the censors, and eight already acted upon were enrolled.

Dr. Swiney, of Bayonne, stated he had a curious case of a baby born with feet and legs swollen, which has persisted for nine months, and the child otherwise seems to be normal. He asked if anyone had seen a similar one. Dr. Rosenstein said he would like to see the case, and Dr. Wm. Doody, 285 Pacific Avenue, stated that he recognized this as a congenital oedema, Malroy's disease, as described by Osler.

The paper of the evening, "Plastic Surgery of the Face. Rhinoplasty" (The Artist-surgeon's viewpoint) was presented by Dr. Luis P. Berne, New York City, accompanied by motion pictures and lantern demonstration.

(We will give the substance of this paper in a subsequent issue of our Journal.—Editor.)

Reports of Other Societies

American Association for the Study and Cure of Cancer.—On October 12th this Association was organized in the New York Academy of Medicine. There were over 60 enrolled from eighteen different States of the Union and some from outside countries, as charter members. Dr. L. Duncan Bulkley was elected President; Dr. Curtis Frank Claassen of Brooklyn, Vice-President; Dr. A. Hirst Appel, Colonel in the Medical Corps, U. S. (retired), Secretary and Treasurer; with an Executive Committee of five. The next annual meeting will be held in Chicago, in May, during the meeting of the American Medical Association.

Plainfield Clinical Society.—This society held an excellent meeting with large attendance in the splendid equipped gymnasium of Dr. H. D. Corbusier, on the evening of November 27th. Dr. A. F. McBride, State Commissioner of Labor, gave an excellent account of the work being done in New Jersey, and a lengthy discussion followed. A trained horse was brought into the gymnasium by its owner that showed intelligence almost equal to that of a human being. Refreshments were frequently served.

Academy of Medicine, Northern New Jersey.—The meetings held in November were: Stated meeting, November 21, paper—"Nature and Significance of Intestinal Stasis," by Dr. Julius Friedenwald, of the University of Maryland.

Section Eye, Ear, Nose and Throat, November 12th. It was clinical night, cases were presented and reports of cases made.

Section on Medicine and Pediatrics, November 13th. Symposium on Poliomyelitis was held: Its Present Status by Dr. Israel Strauss; Pathology, by Dr. H. S. Martland; Neurology, by Dr. C. C. Beling, and Treatment by Drs. Arthur Stern and Edgar Holden, Jr.

Section on Surgery and Gynecology, November 27. Paper on "Carcinoma of Rectum," by Dr. David A. Kraker.

Campaign for Sale of Tuberculosis Stamps

With the slogan, "Stamp It Out With Stamps," coined by its president, Dr. Alexander MacAlister, the Camden County Tuberculosis Association on November 19, 1923, opened its annual campaign for the sale of Tuberculosis Stamps. At a dinner at the local Y. M. C. A., Dr. MacAlister announced plans for the campaign, and suggested the slogan, which was enthusiastically received and vociferously repeated by the diners.

Dr. MacAlister spoke as follows: When one contemplates the great good accomplished by co-operation in philanthropic work, with a very trifling expenditure by every participant, he realizes that if we could get everybody interested in this way the millennium would be on our front stoop and ringing our door-bell tomorrow morning. One wonders why everybody does not see this truth grow when we reflect that the kindly way is the easy way, the "line of least resistance" in other words, that it is more comfortable and profitable to be a good and helpful neighbor than it is to be the other kind of neighbor. Reinforcing this view of the easier way of living is the great truth uttered many times since St. Paul, that we "are every one members one of another," as the sociologist would say (and we physicians would agree with him) society is an organism, and an injury to one member is the concern of every other member, so inseparably do our mutual concerns interlace and intermesh one another.

Tuberculosis, the "white plague," exempts none; rich and poor, old and young, are its victims. Therefore every member of the community should be interested and active in any movement to eliminate it, to make it as infrequent and harmless as smallpox, once a

dreaded and believed to be an incurable disease. I will not dwell upon the horrors of tuberculosis for many of you know them too well, but I will urge upon you greater consideration of the ease with which we may stamp out tuberculosis if we work together, and employ as our instrument, in a co-operative way, this simple little stamp. * * * Let us all get busy, and get all our neighbors busy, and then, all together, raise our slogan: "STAMP IT OUT WITH STAMPS!" and the millennium, so far as freedom from tuberculosis is involved,—will come "running."

NEW JERSEY SANITARY ASSOCIATION

The forty-ninth annual meeting of this association will be held in the Laurel House, Lakewood, on December 7th and 8th. Dr. Elias J. Marsh of Paterson presiding.

The following is an outline of the program: Symposium—School Medical Inspection: a. "What can we do to improve Medical Inspection in rural districts?" Mr. Roy L. Shaffer, Assistant Commissioner of Education, State Department of Education, Trenton. b. "Can Nurses be made available to assist medical inspectors in rural districts?" Mrs. Lotabel J. Gemmell, R. N., Supervisor of Education and Extension, Bureau of Child Hygiene, State Department of Health, Trenton. Discussion opened by Julius Levy, M. D.; H. H. Brinkerhoff, M. D. President's Address—Sanitation and Freedom: Elias J. Marsh, M. D., Paterson. Lighting in Relation to the Eye—Illustrated by Lantern Slides: Prof. C. E. Ferree, and Dr. G. Rand, Bryn Mawr College; Discussion opened by Norton L. Wilson, M. D., Elizabeth and W. T. Blackwell, Mem. Soc. In. Eng., Newark.

The Relation of the Legislature to the Association: Hon William B. Mackay, Jr., Senator from Bergen County; Discussion opened by Hon. W. De Lorenzo, Assemblyman, Bergen County.

The Problem of Pure Air in the Modern City—Illustrated by Lantern Slides; Prof. Yandell Henderson, Yale University.

Sweet Shops and their Problems; Charles V. Craster, M. D., D. P. H., Health Officer, Newark.

Fundamental Defects in Local Health Administration in Rural and Small Urban Communities and Suggestions for their Correction: D. C. Bowen, Esq., Chief of the Bureau of Local Health Administration.

Newer Developments in Public Health Work: A. J. McLaughlin, Surgeon, U. S. P. H. S.—Director, District No. 1.

The One Best Way to Do Work (Lantern Slides): Frank B. Gilbreth, L. L. D., Mem. Soc. Industrial Eng., Montclair.

Report of Committees.

The Executive Council will meet after the evening session, Friday evening.

American Association for the Study of Goiter: Composed of Goiter Surgeons, Pathologists, Anaesthetists, Internists and Radiologists, will hold its annual meeting in Bloomington, Ill., on January 23-25, 1924. An excellent program of papers, demonstrations and diagnosis and operative clinics.

THE JOURNAL

OF THE

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Each member of the State Society is entitled to receive a copy of the JOURNAL every month. Any member failing to receive the paper will confer a favor by notifying the Publication Committee of the fact.

NOTE.—The transaction of business will be expedited, and prompt attention secured if,—

All papers, news items, reports for publication and any matters of medical or scientific interest, are sent direct to THE EDITOR, New Brunswick.

The County Society Secretary shall send promptly to Dr. Morrison, Secretary of the State Society, notice of the election of every new member, with his address; also of any changes of members' addresses.

All communications relating to reprints, subscriptions, extra copies of the JOURNAL, books for review, advertisements, or any matter pertaining to the business management of the JOURNAL are sent direct to THE CHAIRMAN OF THE PUBLICATION COMMITTEE, Newark.

TREASURERS AND SECRETARIES.

PLEASE GIVE ATTENTION.

The Treasurer and Recording Secretary are sending out notices to the treasurers and secretaries of the component societies that the time for the *definite closure* of the Official Lists for 1924 have been set for February 1, 1924. It is necessary to set this date, because the apportionment of State delegates of our Society to the American Medical Association is to be made upon the printed Official Lists in the hands of the A. M. A. on date of April 1, 1924.

Please remember, however, that the annual dues of every member of our State Society should be collected and that the amount of those dues that is for the State Society—five dollars—should be sent to Treasurer Marsh of the State Society before January 15, 1924. The name of every member who has not paid his dues before that date will be omitted from the printed Official List and that omission means loss of standing in the State and National societies. Treasurers should therefore, impress upon the members of county societies what that means of discredit if not dishonor, as well as difficulty in securing re-instatement; that every member therefore immediately on receipt of his bill should send check or post office order for

the same to his society's treasurer or secretary as the bill indicates.

OUR ADVERTISERS

The following editorial from the Journal of the Arkansas Medical Society is equally applicable to the members of the societies represented in the New Jersey Medical Journal:

"Give Our Advertisers a Square Deal"

"Once in a while it behooves us to call attention to our advertisers. Don't lose sight of the fact that the Journal of the Arkansas Medical Society belongs to the members of the society. It is not a private enterprise for private gain and it is supported by the advertisers. Most advertisers trace results. If results are not apparent they cease to use the publications which does not seem to be effective. Therefore it is not only a duty the member of the society owes himself to patronize our advertisers, but to let the firm from whom he buys know that his advertisement was seen in the Journal. Just a line at the bottom of the order, such as 'I saw your ad in the Journal of the Arkansas Medical Society,' will encourage the advertiser to renew his contract with the Journal."

A MEMORABLE CONFERENCE

One of the most interesting, practical and helpful conferences of medical men held this year was that which met at the offices of the American Medical Association in Chicago, Ill., on November 16th and 17th, it being the annual conference of the Secretaries of Constituent State Medical Associations, which the Presidents and the Editors of the Journals of those societies were invited to attend and participate in the presentation of papers and discussions. Special thanks are due to the Trustees of the A. M. A. for the favors extended and to Dr. Olin West for his efforts to make the occasion enjoyable and helpful to those who attended the conference. Special notice of the conference will be found elsewhere.

WELL DONE, WARREN.

We congratulate the Warren County Medical Society on its splendid record in adding recently twenty-eight per cent. to its membership roll. Will not the other county societies follow Warren's example and help make our 1924 State Society roll of members 2,500. It ought not to be less.

LESSONS FROM THE TABLET.

We said in the November Journal that in the presentation of the McKean Tablet our Society performed one of the most notable and most worthy acts in its history, because we regarded the foundation of the Society in 1766 as one of the most important and epoch-making events in the history of our State in relation to the welfare of the State's, the Nation's and humanity's health interests. Dr. McKean and his associates had the true conception of LIFE—that it means SERVICE and service that means any amount of sacrifice needed for its highest and holiest manifestation. That they gave an immense amount of careful thinking and wise planning for such service is evident from the early records, as they realized that they were undertaking a task which tested their faith, courage, loyalty and perseverance in the cause they loved. They had strong faith that its future was full of possibilities for the ennobling of the profession as of heaven-born origin and for the blessing of mankind in its heaven-sent ministries. "The Instrument and Constitutions" were adopted at the meeting in New Brunswick July 23, 1766. That fundamental law was a model document, containing a carefully prepared and admirably adapted plan for carrying out the three-fold object of the Society—"Mutual Improvement; Advancement of the Profession; Promotion of the Public Good," they added—"Cultivation of the utmost harmony and friendship with their brethren," as an important means for accomplishing these objects. The Fee Bill they adopted shows conclusively that pecuniary self-interest was not an object—"ten shillings per week for attendance on the sick, and one shilling for every visit of from one and a half to twelve miles distant." The Ethical Code they adopted was a model, kept according to its letter and spirit would answer every purpose today.

They felt the need of mutual contact, for they were wise enough to know and confess their ignorance and conscientious enough to realize their responsibility in dealing with human life. The honor and advancement of the profession were sacred trusts committed to their care and with a deep sense of accountability they guarded them with zealous care and fidelity. While the science of medicine was then in its infancy, as was the art that applied it, and while the public good

was their highest objective, they were men of far-seeing vision who anticipated great progress, even if they could not foresee the marvelous advances that the on-coming blessings to humanity that Preventive Medicine was destined to bring, they builded better than they knew and it becomes us as we recall their splendid devotion to know duty to recognize our greater responsibility and be as true to our profession and to humanity as they were. As in the past Religion and Medicine were united in service, so now their union is essential for highest success, especially in these days of national and world unrest when the press—secular as well as religious—and our leaders in the business world are declaring that only Religion can bring peace to our troubled world. We believe that our profession is more religious today than ever in seeking to meet its obligations. We may not all believe in creeds, which are man-made, but we can unite in the declaration—CREDO—I believe in God, as we recognize our duty to Him and go forth seeking to discharge it in the best possible service we can render to our fellow men.

We call special attention to the address of our president, Dr. Wells P. Eagleton, which he delivered in presenting the Tablet to St. Peter's Church, Perth Amboy, on November 14th, see page 444.

DOCTORS ACTIVE IN THE WORK OF PUBLIC EDUCATION

We have given under the heading "Personal Notes," a brief account of the banquet given in New Brunswick to Dr. Arthur L. Smith for his devotion to the cause of Public Education. We believe the doctor richly deserved all the commendation given him, but we write especially to commend the citizens of New Brunswick who attended in large number for their intelligent and generous recognition of the service rendered and sacrifices made by this worthy member of our Society who exhibited the true spirit of our profession, as it has been manifested from the days of Dr. Robert McKean to the present day—the spirit of devotion to the Public Good and to the welfare of humanity. The public generally needs to realize the fact that the true physician in rendering such service is not seeking notoriety or applause but he is human and, therefore, appreciation of his efforts, with an occasional "well done," is thankfully received and generally leads to better doing and richer results.

There has been no sphere of the profession's activity that has been more prominent than that in advocacy of, and service in, the great cause of Education. "The Advancement of the Profession" and "The Promotion of the Public Good" as the objects for which our Society was organized in 1766, meant advancement in knowledge and efficiency in caring for and treating the sick, and that, with the increasing efforts to prevent sickness (which means loss of income to the doctor) have demonstrated that the "Public Good," and not the selfish pecuniary interests of the members of the profession, was the controlling motive in organizing the profession, as it has since been and will continue to be. Just as our warfare against quacks, false cults and the dishonest diploma-buying fakirs is waged for the public good, because of their lack of education or utter ignorance in diagnosing and treating disease.

One of the highest manifestations of activity has been, that in recent years, in Public School Education, medical inspection of the children for the discovery, eradication and prevention of disease and the correction of deformities has been carried on most effectively. It has been claimed that the seeds of disease enter the body in early childhood and are generally dormant until later years, but when we know that large numbers of children die within one year and vast numbers within five years after birth, it seems evident that such children were born with actual or developing disease. We may do much to save those children, but we have done more and will do vastly more in saving the older school children from the on-coming of actual disease and in the building of healthy strong lives. Who can estimate what that work means in the "Promotion of the Public Good" in the city, state, nation and the world?

RETAINING THE PHYSICIAN.

The problem in certain rural communities concerning competent medical attention has been solved in some sections by the people providing a stipulated sum sufficient for a reasonable livelihood contributed to the physician in advance. For this sum the physician undertakes to attend the people in their ordinary illness but is entitled to extra compensation for certain extraordinary work.

We have observed accounts of such an arrangement in several States but recently

the first instance of the kind coming to our attention was mentioned in news dispatches from Martinsburg, Missouri, which state that the people of Shamrock, a town about ten miles from Martinsburg, upon learning that their physician was about to leave because of inability to gain a reasonable living among them in his professional work, held a meeting and collected more than \$1,000 which was paid to the doctor in advance. It is also stated that they requested the physician to raise his fees for service commensurate with the necessities of living. The physician has agreed to remain at Shamrock.—Missouri State Jour.

PROCLAIM YOUR CAUSE THROUGHOUT THE LAND UNTO ALL THE INHABITANTS THEREOF.

Few physicians appreciate the changing conditions of recent years in the practice of medicine. Few doctors are conscious of the lack of business acumen on the part of the medical fraternity in meeting these changed conditions, which menace the lives of thousands of people and stultify the influence of the profession. Lack of comprehension of the many serious problems confronting us coupled with passive acquiescence and a feeling of false security regarding the safety of the future of medical practice, is responsible for a drift towards dangerous shoals. There State Medicine, socialization of medicine, Workmen's Compensation, Pay Clinics, Compulsory Health Insurance enactments loom large ahead and cast their shadows before them.

Awakened public opinion is the greatest force in existence, but public opinion is not a self starter. Artificial stimulation is essential. For generations the medical profession has been living in a state of self-hypnotism, satisfied with developments as they are and regulated by a restricted code of ethics, that has denied the physician his inalienable right to be heard. As a result the profession has lost caste with the public. The doctor is misunderstood. This lack of comprehension of the doctor and his works has allowed the many cults and isms to creep in and jeopardize the health welfare of the people.

At no time have the recognized schools of medicine done anything to offset the effects of new and erroneous curative theories that are constantly being put forward in the guise of systems of med-

ical practice. One by one, these cults blossom out and secure a following among the people. Organized medicine has failed to make serious attempt to counteract this evil by education of the public to the tremendous strides made in medical sciences and showing the public what medicine has accomplished, is accomplishing and will accomplish towards the cure and prevention of disease.

Our medical organization must be up and doing. The time is at hand when organized medicine, with the welfare of the profession at heart, must study the trend of the times and recognize the innumerable dangers confronting the future of medicine. Solution of our medical problems lies in the better understanding by the body politic of the accomplishments of medical science.

It is only natural to expect that laws relating to the health of the people should emanate from the medical profession. In actual experience, the exact opposite is the rule. We have but to scrutinize the thousands of proposed bills affecting the practice of medicine, and also to not the vast number of laws yearly enacted, affecting the health welfare of the people and observe that in a great majority of instances, how the recommendations of medical men have failed and those of the sentimentalists and theorists have guided the enactment of medical laws. In most instances those whose knowledge should have been followed in directing medical legislation, have had little or no voice. There is something wrong with the law-making bodies and that something is lack of enlightenment of the public. In this important matter, the burden of education of the public, rests upon our profession. The doctor and his deeds must be brought back into the confidence of the public, and only he himself can effect this return to the fold. What he has wasted through negligence, even though it be the negligence of our modesty, the doctor can regain only by diligent missionary work in behalf of the mother profession and let it not be thought for a moment but that this missionary work is a sacred trust that each physician must set about performing. It is part of his dedicatory oath that he should conserve the health of the people and he is not only betraying the mother science but actually he sells himself, his fraternity and the people they are con-

secrated to serve—sells them into a bondage of sickness and death—when he sits idly by and permits the public to be humbugged.

If medical achievements were better understood by the public, the voice of the profession would be increasingly a factor in constructive health legislation, that would ultimately redound to the betterment of the laws and the security and respect of the profession.—From the Illinois Medical Journal.

SAVING THE BABIES

Citizens who live in communities apathetic to their infant death rate should consider carefully the results of the co-operative rural health work now being carried on in Green County, Missouri. A report just received by the United States Public Health Service at Washington shows a remarkable reduction in the infant mortality rate in Springfield and Campbell townships since the establishment there of a whole time county health department.

In 1918 the death rate in these two Missouri townships was 105 per thousand. That is, out of every 1,000 babies born alive, 105 died in that year. Then Green County decided it could no longer afford to continue unmindful of its baby death rate, and a health department was organized. In the following year, 1919, the infant death rate in these two townships dropped to 96 per thousand. In 1920 it went to 85, in 1921 to 76, and in 1922 the decline reached 61. In other words, Springfield and Campbell townships reduced their infant mortality rate 42 per cent. within the short space of four years. This 42 per cent. reduction furnishes a striking example of what may be accomplished in infant welfare by carrying out, with economy and efficiency, a well-balanced general program of health work affecting all age-sex groups in a community with a well-administered health department under the direction of a whole-time health officer.

The example of Missouri in saving its babies should be followed by other communities not equipped with health departments or health officers giving their full time to the work. It is time for the thinking men and women who live in such communities to organize; time for them to shake off their indifference, and set about earnestly to save the lives of babies born in such communities. A county health department under the direction of a full-time health officer is the first objective.

Missouri is showing the way.—Boston Med. and Surg. Jour.

ROGUE DOCTORS.

We call special attention to the articles on pages 448 and 449 on "Fake Doctors," and to the following editorial from the N. Y. Tribune of November 30th:

"Rogue Doctors.

"The fake doctors of Connecticut are not the only men who degrade the medical profession. Physicians in this State, duly licensed, not uneducated, choose to prey on the immigrants by promising impossible cures and every other sort of chicanery. Foreign language newspapers are the favorite vehicle of these sharks. The owners of the papers—with honorable exceptions, no doubt—are willing to prostitute their advertising columns for the gain there is in the business.

"Dr. Antonio Stella of the New York County Medical Society, testifying before the legislative committee which is investigating the exploitation of immigrants, has asserted that the average paper printed in a foreign tongue receives from the quacks between \$100,000 and \$150,000 a year.

"Dr. Stella suggests that the medical societies be empowered to deal with the fake cure rascals as the bar associations deal with shyster lawyers. Reputable physicians would like nothing better than to do a thorough job of housecleaning in their profession and put the charlatans out of business if the Legislature would delegate the task to them. Something should certainly be done at Albany to relieve the stench of the medical scandals so far as New York is concerned."

Next month we shall have something to say on the question—How far are the one thousand or more doctors in New Jersey who are supposed to be regularly educated and licensed but have not identified themselves with our county medical societies, responsible for this condition, some of whom are serving in hospitals or clinics?

"God give us men. The time demands Strong minds, great hearts, true faith and willing hands:

Men whom the lust of office does not kill;
Men whom the spoils of office cannot buy;
Men who have honor; men who will not lie;
Men who can stand before a demagogue
And damn his treacherous flatteries without winking;

Tall men, sun-crowned, who live above the fog
In public duty and in private thinking."

—John G. Holland.

REINSTATED AND NEW MEMBERS OF THE MEDICAL SOCIETY OF NEW JERSEY

Buzby, Benjamin F., Camden.
Davenport, Irwin P., Blackwood.
Del Deo, Nicholas V., Newark.
Dunphy, Edwin B., East Orange.
Fischer, Armin, Newark.
Griffith, Roy, Newark.
Hauck, Lydia B., Newark.
Jones, William R., Montclair.
Kaufman, E., W. Camden.
Keller, Paul, Newark.
Lauterborn, Thomas W., Belleville.
Lincoln, Jennings S., Montclair.
Lovell, Frederick H., Newark.
Luban, Benjamin, Newark.
Mendelsohn, Abraham, Newark.
Salsberg, Ralph A., Montclair.
Sellers, Robert T., Newark.
Swain, Richard T., Newark.

Correspondence

Problems in Solving Health Problems in Education

(Dr. Harry W. Haight, Highland Park, has been appointed chairman of the committee on Health Problems in Education.—Editor.)

To the Editor of the Journal:—

The announcement recently made by the Honorable John Enright, State Commissioner of Education, that henceforth there will be an annual examination in the eighth grade of the public schools in the subject of Health and Hygiene comes the first victory for this committee.

Efforts to secure the establishment of a Bureau of Health in the State Department have been renewed. Contact with the National Committee has been established. When we reflect that enlightenment is fundamental to co-operation and appreciation of our efforts in every case which we attend, we realize not only the importance of this work from a health and humanitarian point of view but from a material and economic aspect as well. Health education extends life and enriches the field of the practitioner.

Harry W. Haight, Chairman.

Group Policy U. S. Fidelity and Guarantee Co. Newark, N. J. Nov. 19, 1923.

Dr. D. C. English, Editor:

After some correspondence with The United States Fidelity & Guaranty Company, we have succeeded in having the terms of protection under the group policy, amended to read as follows:—"And that said policy, subject to all its terms, limits, agreements and representations, provides to defend and indemnify the assured named herein, within the amounts as expressed in the policy against actual loss and/or expense arising or resulting from claims upon the assured for damages suffered or alleged to have been suffered by any person or persons in consequence of any malpractice, error or mistake committed or al-

leged to have been committed during the policy period provided herein (a) by the assured in the practice of his profession; (b) by any practicing physician, surgeon, dentist or qualified nurse while acting as an assistant under the assured's professional instructions, save and except claims; (1) caused by the assured while in any degree whatever under the influence of intoxicants or narcotics; (2) caused by the assured while engaged in or in consequence of the performance of an unlawful act."

This amended policy does away with the former limitation "on account of bodily injury or death," specifies the assistants as "practicing physicians, dentists, or qualified nurses," and by the phrase "person or persons," in line seven, protects against suit by relatives for loss of service on account of malpractice.

Yours truly,
J. B. Morrison, Secretary.

Quantity of Liquor Allowable

Basking Ridge, N. J., November 12, 1923.
Federal Prohibition Director,
Newark, N. J.

Dear Sir:

Within a few days I shall have under my care a man who has been operated upon for cancer of the throat and who is unable to swallow solid food. At present he is sustaining life on a diet consisting of peptonized milk, eggs, sugar, butter and whiskey and I am informed that he is doing well on this and is gaining strength.

The daily quantity of whiskey in this formula is two and one-half ounces which is slightly in excess of the pint in ten days ordinarily allowed.

I am writing to ask you if there is any way by which this quantity of whiskey can lawfully be supplied to this patient.

Very truly yours.

Philip Embury, M. D.

Treasury Department

Newark, N. J., November 14, 1923.
Dr. Philip Embury,
Basking Ridge, N. J.

Dear Doctor:

Reference is made to your letter of the 12th inst. relative to the propriety of prescribing or administering a quantity of whiskey in excess of one pint in ten days to a patient now under your care.

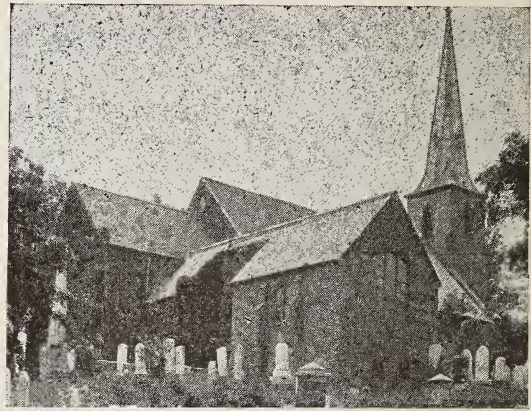
While the case mentioned by you is undoubtedly meritorious, we are compelled to call your attention to Sections 71 and 77 of Regulations 60, which state that the total amount of spirituous liquor administered or prescribed by one or more physicians to one person in a period of ten days may not exceed a pint.

You will, therefore, see that this office has no prerogative in the matter, except as stated above and therefore, no quantity of liquor in excess of one pint may be legally prescribed or administered to one patient in a ten day period.

Yours very truly,
(Signed) Adrian G. Chamberlin,
Federal Prohibition Director.

TABLET TO DR. MCKEAN.

BY THE STATE SOCIETY



St. Peter's Episcopal Church,
Perth Amboy, N. J.

IN MEMORY OF
THE REV. ROBERT MCKEAN,
A.M., M.D.
FOUNDER AND FIRST PRESIDENT
OF
**THE MEDICAL SOCIETY OF
NEW JERSEY**
JULY 23, 1766
THIS TABLET IS ERECTED
(Seal) BY THE SOCIETY (Seal)
1923

Temporary Tablet placed in the Church till the permanent one is completed.

The slab on the doctor's tomb in the church yard has the following inscribed thereon:

In Memory of
The Rev'd Robert McKean, M. A.

Practitioner in Physics
And Missionary from the Society
For the Propagation of the Gospel
In foreign parts

To the City of Perth Amboy,
Who was born July 13th, 1732, N. S.
And died October 17th, 1767.

An unshaken Friend
An agreeable Companion
A rational Divine
A skillful Physician
A truly benevolent and
Honest Man.
Fraternal Love hath erected
this Mounment.

Two history making services were held in St. Peter's Episcopal Church, on Sunday, November 14th, which was the big day in the week's celebration of the 225th anniversary. The first service was held at 10.30 A. M., when Rt. Rev. Paul Matthews, bishop of the diocese of New Jersey was the celebrant at holy communion and a historic sermon was preached by Rev. C. Rockford Stetson, D. D., rector of Trinity church, New York City.

The second service, was held at 4 o'clock in the afternoon at which time the church was crowded to the doors and chairs were placed in the aisles. Rev. Edwin S. Lines, bishop of the diocese of Newark presided, with Rev. W. Northy Jones, rector of St. Peter's assisting.

Besides the address of Bishop Lines, the features of this service were the address by Governor George S. Silzer, and the presentation of a tablet in memory of Dr. Robert McKean by the Medical Society of made by Dr. Wells P. Eagleton, of Newark, New Jersey, the presentation speech being President of the Medical Society.

Bishop Lines, in an eloquent address on the early history of the church in New Jersey, recalled the early life of St. Peter's church and the activities of Rev. Robert W. McKean. He spoke briefly of the need of doctors being so great in the new world that many of the early rectors spent extra time in Europe to prepare themselves not only to serve God, but also to administer to man's physical wants. "Members of no profession give more than doctors do," said Bishop Lines, "and they had a large place in the development of the religious and civil life of the state."

After an eloquent address by Governor Silzer, Rev. W. Northy Jones in introducing Dr. Wells P. Eagleton, declared the service to be an epoch making one, as not only was the governor of the state present, but also members of the oldest medical society in the United States. He then spoke of the life of Rev. Dr. Robert McKean, who is buried in the church yard as one who held many offices successfully. He was a doctor and a rector and a school master all at one time. Mr. Jones pictured the great change that had taken place since the time when one man could hold so many positions. Besides being a rector and a schoolmaster in this city as a physician Dr. McKean covered the territory extending from New Brunswick to Perth Amboy, including Woodbridge and Piscataway.

ADDRESS ON MCKEAN TABLET PRESENTATION.

By Wells P. Eagleton, M.D.,
Newark, N. J.

Address of Dr. Eagleton, President of the Medical Society of New Jersey, at Saint Peter's Church, Perth Amboy, N. J., Sunday, November 4th, 1923, on the occasion of the presentation of a tablet by the Medical Society of New Jersey in memory of DOCTOR ROBERT MCKEAN, the first President of the Society.

Robert McKean, one of the incumbents of this parish, was a practitioner of medicine as well as its pastor, choosing, as did many others of the English colonists, to study both theology and medicine. He practiced two of the three callings which may truly be called professions; for I think one can only be said to practice a profession who, not only has learning, but when that learning is applied to the relief and advancement of humanity. And of all the trades and crafts, but three fulfill these requirements—medicine, theology and pedagogy. For today, as in the time of McKean the clergy are striving to improve the spiritual life of man, the educators are trying to develop his mind, and the physicians are trying to relieve his sufferings and to develop his body and through it, his spirit.*

During the life of Robert McKean, physicians were generally regarded as religious because they attended church. Today physicians are regarded as irreligious. Physicians are not irreligious. As a class they are deeply religious because no one can follow the spirit of medicine without becoming imbued with the gospel of love. Physicians are not irreligious, but their education and experience have taught them that no single creed contains within itself all the element of human life.

But it is not because Dr. McKean was a preacher, or even because he was a physician, that the physicians of today wish to perpetuate his memory—it is because of the standards which he and his associates set for those of us who have followed—it is because of what he did to put a proper spirit in this organization of the physicians of this State.

Dr. McKean and seventeen others founded the Medical Society of New Jersey in 1766, ten years before the Declaration of Independence, this being the first State medical organization to be established on

*Eagleton, Dr. Wells P., "Idealism in Medicine," Journal Med. Soc. of N. J., 1913.

the new continent. And while we are proud that our State Society is the oldest in the United States, this of itself would not warrant our paying unusual honor to Robert McKean were it not for the principals which he and his associates laid down at that time for our guidance.

We especially honor those of our ancestors who have looked forward, and it was because of the practical ideals enunciated by Dr. McKean that physicians are gathered here today.

The "Instruments of Association and Constitution of the Medical Society of New Jersey" of 1766 had for its objects "Mutual Improvement, the Advancement of the Profession, and the Promotion of the Public Good." This call to the organization meeting read that they, the organizers, being "desirous of extending, as much as possible, the usefulness of their scheme and the cultivation of utmost harmony and friendship with their brethren, request and invite every gentleman of the profession in the province that may approve of their design to attend the first meeting."*

These, then, were the principals that were set before the profession by Dr. McKean and his associates—"Mutual Improvement, the Advancement of the Profession, the Promotion of Public Good," and an invitation to every gentleman of the profession to join them.

See how idealistic their aims were. Mutual Improvement—this means spiritual and mental growth, not material advantages. Advancement of the Profession—not protection of the profession,—but advancement of the profession as being the means whereby medical knowledge and usefulness is increased. In the organization of the Medical Society of New Jersey of which Dr. McKean was the first president, there was no suggestion of their asking any protection for themselves.

Promotion of the Public Good—then, as now, physicians must recognize that they belong to the public. For by their years of training, by their ethical standards, by the culture which has become theirs from years of research and thought, physicians are especially qualified to understand human needs; but in the fascination of the study of the individual's disease, in the very love

and wonder of medicine, they have but too often been lead away from their larger duty to the public as a whole.

Too long has the medical profession allowed the State to be guided by laymen in matters of public health in which physicians alone are qualified to act. All laws to be truly beneficial must be based on an understanding of psychology and physiology as well as customs and principals. To disregard this is to invite disaster.

What did they mean by being a gentleman? How old-fashioned it sounds to us. But although we seldom use the term, down in our inner consciousness we still mean a man who has character, who has education, and who is truthful and honorable in his dealings, not only with others but with himself. He must possess culture and a certain fineness of thought and action which distinguishes him from others. The Chinese have a custom. When they enter into a contract, the man does not sign his name to the contract but makes a memorandum of the contract on a piece of paper, which he puts in his own pocket and keeps, thus making a contract with himself. A man who will fulfill such a contract is a gentleman. And every day, every member of the medical profession, every member of the clergy, must make and fulfill such a contract. For they are the custodians of humanity's personal tragedies and these must be forgotten the next moment.

These are the ideals which the profession, in spite of changing times, must hold before it. Manners and customs change—did not this church itself once have a lottery to raise money—but ideals never change; they grow!

But a few miles from Robert McKean's grave stands Highland Light, the first light seen by incoming ships as they approach New Jersey's shore, its great track of light flashing always northward, on its path illuminating Sandy Hook, and has said to thousands of storm-tried mariners, "this way, this way to safety behind the Hook." The medical profession of New Jersey of today honors Dr. Robert McKean because he formed a society for Mutual Profession, the Promotion of the Public Improvement, the Advancement of the Good, and the invitation to all the gentlemen of the profession that may approve of these principals, to join. These principals have been the Highland Light of the medical profession during all these years. They still say "this

*Wicks, Dr. Stephen, "History of Medicine and Medical Men in New Jersey," page 329.

Whitehead's "Early History of Perth Amboy," page 225.

English, Dr. D. C., "Our Medical Society; Its Past Success," etc., 1895, page 121.

way, this way" as much in 1923 as they did in 1766.

As President of the New Jersey Medical Society, and in its name, I present herewith a tablet in memory of Dr. Robert McKean to this parish.

The following letter has been received from Dr. Jones:

St. Peter's Rectory

Perth Amboy, November 26, 1923.

My dear Dr. English:

I wish in behalf of the minster, churchwardens and vestry of St. Peter's Church in Perth Amboy to extend cordial thanks to the Medical Society of New Jersey for their thoughtfulness in erecting a tablet in the porch of St. Peter's Church in memory of their beloved founder and first president, Dr. Robert McKean.

We are grateful too, to Doctor Eagleton for his splendid address of presentation on the occasion of our anniversary. Please convey to the Society and to Doctor Eagleton our cordial appreciation.

Very sincerely,

W. Northey Jones.

NEW JERSEY MEDICAL SOCIETY WELFARE COMMITTEE

Welfare Committee, Medical Society of New Jersey, other physicians, Advisory Boards and physicans of State Rehabilitation Clinics and Compensation Referees and other members of the Compensation and Rehabilitation Divisions of the State Department of Labor.

At the Essex Club, Newark, October 28th, 1923. A conference on the medical phases of the Workman's Compensation Law was held.

Those present were:

Camden County, Drs. A. Haines Lippincott, Alexander H. Ross.

Essex County, Drs. Wells P. Eagleton, John Hagerty, Robert E. Soule, John N. Bassin, Edgar Holden, Jr., Charles A. Rosewater, William A. Goodwin, Henry B. Kessler and Marcus C. Avidan.

Hudson County, Drs. Frederick J. Quigley, Gordon K. Dickinson, William J. Arlitz, Samuel A. Cosgrove, Donald Miner, Henry Spence.

Mercer County, Drs. Henry B. Costill, Martin W. Reddan, N. B. Oliphant, Frank G. Scammell, Richard B. Ernest.

Middlesex County, Dr. E. Irving Cronk.

Passaic County, Drs. Andrew F. McBride, Thomas A. Clay, Walter B. Johnson, Elias J. Marsh, Norman T. Cotton, Fred Vosburg, James M. Stewart.

Union County, Dr. George T. Banker.

Department of Labor: Compensation and Rehabilitation Divisions—

Compensation Deputies, H. J. Goas, Charles E. Corbin.

Assistant Director New Jersey Rehabilitation Commission, Jos. Spitz, Wm. Z. Stubbs. Referee, William J. McMichael.

Dr. Wells P. Eagleton, President of the

Medical Society of New Jersey, called the meeting to order and explained that it was held for the purpose of seeking information that would aid in guiding the Welfare Committee of the State Medical Society in presenting amendments to the medical clauses of the Workmen's Compensation Law, if it were deemed advisable to do so. He said what it was desired to discuss was:

The relation of the physician to the State. The relation of the physician to the carrier. The relation of the physician to the employer. Is the law working satisfactorily to the physician? Is the law working satisfactorily to the State? Is it desirable to modify the Workmen's Compensation Law? Is it desirable that the law should be amended as it effects the injured workman? Is it desirable that the law should be amended to give the injured workingman the right to choose his own physician?

Dr. Eagleton requested Dr. Andrew F. McBride, a member of the Welfare Committee and State Commissioner of Labor, to preside. Dr. McBride accepted saying that it was a very commendable thing to bring together the representatives of the Medical Society, the State Department of Labor, to discuss the medical phases of the Workmen's Compensation Law, and that he believed that much good would result from it.

That discussion might be conducted, Dr. Costill moved that it be sense of the meeting that the Workmen's Compensation Law as it affects physicians, is satisfactory. Dr. Quigley offered an amendment that it was the sense of the meeting that the present Workmen's Compensation Law was not satisfactory to the physician. The amendment was accepted for discussion.

A general discussion followed, the high points of which were: A difference of opinion as to whether the workingman should have the right to choose his own physician. The majority of doctors thought he should, some said there were reasons for and against such a change. The representatives of the Compensation Bureaus expressed the belief that better results would be obtained if the employers were allowed to continue with authority to select the physicians. There were practices in connection with the operation of the law, which all agreed should be eliminated. Some of the physicians thought an investigation should be made of the Massachusetts law, which gives the employee a right to choose his own physician, with a check up by the employer's physician, if desired.

Complaints that insurance companies were refusing to pay for hospital and physician's charges on cases treated in the wards of Pater-son hospitals. Mr. Stubbs of the State Department of Labor said that the department had ruled that such services should be paid

The point was raised that there should be a change in the law which would provide for the engagement of expert medical advice for the injured workmen in court cases. All speakers agreed that such a provision was very desirable for the protection of the workingman.

Complaint was made that injured workingmen are required to travel long distances for treatment, and in some instances to travel out of the State to dressing stations maintained by insurance. It was declared by officials of the

State Compensation Bureau that such practices were contrary to the law.

As a conclusion to the meeting it was moved and carried that the matters of deciding on amendments to the law be referred to the Welfare Committee and the State Commission of Labor.

On motion the meeting adjourned.

Joseph H. Gunn, Secretary.

CONFERENCE OF STATE SOCIETIES' OFFICERS

This conference has been held annually for several years according to the action of the Board of Trustees and the House of Delegates of the A. M. A. Heretofore it has been a conference of the Secretaries of the State Society, but this year the Presidents of State Societies and the Editors of the Journals were invited to attend. There were present 33 secretaries, five presidents and six editors, beside the secretaries who are also editors. With them the President, President-elect, Secretary and the Treasurer of the A. M. A. and all the members of the Board of Trustees and heads of departments of the A. M. A.

The following was the program:

What Measures Can Be Initiated by County, District and State Medical Societies for Increasing Organization Efficiency and for the Promotion of the Professional and Economic Status of the Physician? W. F. Donaldson, Pennsylvania.

Postgraduate Courses for County Societies, A. H. Bunce, Georgia.

Diagnostic Clinics, A. T. McCormack, Kentucky.

The Program for Regular Meetings, W. G. Ricker, Vermont.

Fee Schedules and Collections, J. F. Hassig, Kansas.

How Can the Medical Profession in Its Organized Capacity Best Inform the Public Concerning the Benefits That Scientific Medicine Makes Available? C. B. Drake, Minnesota.

The Plan of the State Medical Association of Texas, Holman Taylor, Texas.

The Functions of the Bureau of Health and Public Instruction if the American Medical Association, J. M. Dodson.

Educational Effort Through the Public Press, E. J. Goodwin, Missouri.

The Attitude of the Medical Profession Toward Cults, J. F. Gallagher, Tennessee and W. D. Chapman, Illinois.

8 P. M. round table conference of editors of State Medical Journals, after the dinner at Hotel Virginia.

Organization of County Medical Societies for Promoting Periodic Medical Examinations, B. L. Bryant, Maine.

Medical Defense and Indemnity Defense Funds, E. W. Pope, California.

Automobile Liability Insurance, G. H. Winfrey, Virginia.

The Activities of the Bureau of Legal Medicine and Legislation, W. C. Woodward.

Miscellaneous Topic.

Dr. Olin West, Secretary of the A. M. A. who did much for the success of the conference, says: "I wish that all of the States had been as well represented as was New Jersey, whose President, Secretary and Editor were

all on hand—All three took an active part in the discussions.

Dr. J. B. Morrison spoke of the entire success and satisfaction in New Jersey of its system of Medical Defense and Group Indemnity Insurance and also of the attitude of the profession in New Jersey toward the protection of the public health and welfare by legislative enactment requiring a high standard of preliminary and basic medical and scientific education of all who engaged in the practice of medicine.

Dr. W. P. Eagleton spoke of the influence of the physician in public office as increasing throughout the United States and the sentiment was growing that physicians should be the leaders in medical matters as they relate to public welfare. There is also a growing demand among the laity, he said, to have medical men handle medical problems, due largely to the educational movement on the part of physicians, that the medical men are by their training the best fitted for such matters. He outlined the work in connection with public affairs as done by the members of the medical profession in his State, through the activities of the welfare committee of the State Medical Society. New Jersey he said, was in the front rank of states in this connection.

At the Round Table Conference of Editors, Dr. English gave a brief talk on the work in New Jersey and asked whether it would be wise to organize the Editors into a Society that would meet semi-annually—at the annual meeting of the A. M. A. and at this annual conference with a pre-arranged program. The Editors present deferred action on organization, but voted to request the A. M. A. to arrange for the Presidents and Editors to meet again with the Secretaries at next year's conference.

Dr. English referred to the Conference the Welfare Committee had with Governor Silzer, which resulted in his appointing an Advisory Board of Medical Men to confer with him and with the State Institutions Managers' on legislation and on business of the Institutions which involved medical questions needing their advice.

Connecticut's Fake Doctors Danger Signal to New Jersey

Missouri's "medical mills," the ease with which paper qualifications from high school diplomas to degrees in medicine and surgery can be bought for cash in some parts of the country, and Connecticut's own laxness in testing the fitness of candidates for licenses as doctor's, have combined to make the tragic scandal which has been exposed in the Nutmeg State.

The example is one which applies with singular force to warning New Jersey. For three years past there has been a determined effort to break down the bars this State has raised against the entrance into the healing arts of men not qualified to practice those arts. It is not necessary to detail that record, but it is important to take note once more, in the light of the Connecticut experience, that the same assault is still under way, though in different guise.

This is the effort of the State Council of the

American Legion to force compliance with a construction of the law which apparently would make war service, plus reconstruction training in the form of courses in chiropractic, sufficient warrant for the licensing of wounded ex-service men as chiropractitioners.

Practitioners of any method of healing take the lives of the people in their hands. There is no check upon them, after licensing, but the degree of their skill and responsibility. The State's duty to safeguard the people, therefore, requires that due knowledge of the healing art sought to be practiced, and possession of the high moral character which must accompany so grave a responsibility, shall be demonstrated adequately, not by paper attests, but by rigid examination.

Not only as to the effort to have ex-soldiers made doctors of chiropractic on mere paper qualifications, but with full regard for the persistent efforts made in the past to break down the standards of our medical laws, New Jersey should take due warning from the Connecticut experience, with the consequences of leaving the medical door wide open for the entrance of the unqualified and the faker of medical knowledge.—Newark Evening News.

QUACK DOCTORS IN NEW JERSEY

A distinctly marked trail leading into New Jersey and indicating that quack physicians have opened here as well as in Connecticut, New York and Massachusetts has been uncovered in the investigations at Hartford, Conn. Documentary evidence prepared for submission to the extraordinary grand jury when it resumes its inquiry into illegal medical practice includes letters seized by Missouri state police in a raid October 15 on the home in St. Louis of Dr. Robert Adcox, one of three men indicted there in connection with the issuance of alleged fake diplomas from the Kansas City School of Medicine and Surgery.

One of these letters concludes:

"Dr. W., of C., begs me to state that he is waiting certain papers from the K. C. College, which have upon them the seal of that institution. The great seal of New Jersey will smile upon such papers, but they must have said seal affixed."

This letter bore the code signature "18 and 96."

A memorandum found among Dr. Adcox's effects was a request for diplomas. It was unsigned and was enclosed in an envelope postmarked Connecticut.

"Kindly rush them through," it reads. "The board through which the papers are going to pass does not pay much attention, as they, too, have to grant certain rights of way. One of them is for Jersey. I know the Jersey man. See that they have the seal."

Dr. S. H. Osborn, the Connecticut State Health Commissioner, already has selected 200 cards signed by "doctors" examined by the Eclectic Board, and says that at the present rate the force he has at this task may turn up thousands more. The latest suggestions for grand jury investigations is that of deaths at hospitals of persons sent in at the eleventh hour by quacks who saw the game was up, and avoid unpleasant embarrassment by recommending removal to a hospital, where

the death certificates were signed by the physician present at death.

Many states in the country which have so-called reciprocal relations with Connecticut will be advised of the present developments in Connecticut so that local inquiries may be begun into the work of the many "doctors" who passed the Connecticut Eclectic examination and moved on. It is estimated that one-half of those who recently passed the Connecticut board failed to locate in that state, where there were 200 fakes when the investigation began.

One of the interesting institutions that the Hartford grand jury will be called upon to look into in its investigation of the fake diploma ring is Oriental University, of Washington, D. C. Its dean and founder Bishop Holler, is under indictment in Washington for use of the mails to defraud, while the postal authorities have issued a fraud order forbidding his college the use of the mails. In a circular sent out by this institution it is indicated that most of its courses are by correspondence and that in seventeen years it has had 884 correspondence students.

The Connecticut authorities have discovered that the diploma "mill" conductors had certain set prices on their certificates, the market quotation for which took a sudden slump with the opening of the Connecticut investigation. For instance:

A high school certificate which purported to be the equivalent of a high school diploma, indicating that the student had passed all his subjects, could be purchased for \$25.

A high school diploma, indicating that the student had graduated—\$100.

A high school diploma, supported by records to the effect that the student actually attended classes and was graduated—\$150.

A pre-medical credit, showing that the student had done two years college work—\$100.

A medical credit, showing that the student had completed the studies of the freshman, sophomore and junior years of a medical school—\$300.

A medical credit, to show that the student attended college—\$600.

First class medical diploma—\$750.

Second class medical diploma—\$500.

Third class medical diploma—\$250.

These diplomas were graded down to a product as cheap as \$25, which were usually issued by institutions that existed only on paper, and the certificates of which were hardly worth the paper they were printed on.

A chiropractic diploma, \$15.

A chiropractic diploma, with three-day courses of instruction, text books on technique and a table for use in the so-called adjustments, \$69.50.

An Eclectic Medical License in Connecticut and Arkansas could be purchased for \$100 to \$500, the cost depending entirely upon the amount that could be squeezed from the prospects' pockets.

An allopathic medical License in "easy" states—\$250 to \$750.

Repeating licenses, from which the name of the original holder had been erased and another substituted, \$100.

Licenses in New York, Illinois, Massachusetts and other states with stiff medical practice acts and examining boards whose integrity

could not be doubted, and where it was necessary to have proxies to take examinations in the name of the person who wanted the license, \$1,000.

Miscellaneous Items

The Physician.—There are men and classes of men who stand above the common herd, the soldier, the sailor, the shepherd not infrequently; the artist rarely; the physician almost as a rule. He is the flower of our civilization and, when the stage of man is done and only to be marveled at in history, he will be thought to have shared as little as any in the defects of the period and most nobly exhibited virtues of the race. Generosity he has, such as is possible to those that practice an art, never, to those who drive a trade. Discretion, tested by a hundred secrets, tact tried in a thousand embarrassments, and, what are more important, Herculean cheerfulness and courage.—Robert Louis Stevenson.

Not Every Doctor a Surgeon.—It is an unfortunate fact that there are physicians in considerable numbers who have never received the requisite training, but who are trying to do surgery. To many of our people a hospital is a hospital and any doctor a surgeon. A way must be found to protect these people. There should be some recognized mark of the competent surgeon and the trustees of all hospitals could then forbid others to operate in their institutions. The private commercial hospital would probably require state regulation.—F. A. Washburn, Mod. Hosp.

Medical Aid For All.—Medical Aid of the same sort for everyman regardless of his economic status will be the next forward step of the medical profession in the United States, Dr. Ray Liman Wilbur, president of the American Medical Association, and of Leland Stanford University, of California, told doctors at the Tristate Medical Association convention in address at Des Moines recently. "If doctors could apply all they know to all the people, not only would life be prolonged and human happiness increased, but the whole aspect and order of life would be altered," he declared.

Alleged Cure for Tuberculosis.—Early in May the Associated Press carried a story from Pittsburgh to the effect that one, Dr. W. P. Nolan, had described "a cure for pulmonary tuberculosis by the use of pure carbon and calcium." Readers who have followed the editorials in Hygeia on the inhalation of dusts will realize the basis for Dr. Nolan's belief that he had described a remedy of benefit. It rested on the fact that workers in lime, a form of calcium, seem to have tuberculosis less often than do others, and that the inhalation of coal dust seems to produce changes in the tissues of the lungs similar to those which accompany the healing of lesions of tuberculosis. Unfortunately, such reliable experimental evidence as is available does not warrant the assumption that treatment such as that suggested by Dr. Nolan would have any curative effect in tuberculosis. The facts are that his "consumption cure" is essentially secret in

composition, is put forward on a basis of utterly inadequate tests made only by himself, and is exploited in connection with an instrument sold only by its inventor. The tragedy is not in the fact that a reputable physician has allowed his enthusiasm to run away with his judgment, but that thousands of optimistic consumptives are to have their hope of a quick cure blasted again.—Hygeia.

Extent of Period of Temporary Total Disability (Peabody Coal Co. v. Industrial Commission et al (Ill.), 139 N. E. R. 7).

The Supreme Court of Illinois says that an employe of the coal company sustained a severe injury to his left arm. It appeared that he went back to his work in the mine two or three different times before he found that he could not keep on working because he could not lift his arm. The court thinks that the finding of the industrial commission that the man was totally incapacitated for twenty-six weeks found support in the testimony—that is, the time of treatment for six months, deducting the time he worked and received compensation and adding the time for the building-up process immediately following the time of treatment. Under the decisions of this court, the extent of the period of temporary total disability is the period of the healing process, during which time the injured employee is totally incapacitated for work by reason of the illness attending the injury. The fact that this employee attempted to perform labor at the mine and failed should not stand as a bar to prevent his receiving compensation for the time he was incapacitated, and this court thinks the time for the building-up process was properly included as a part of the period of temporary total incapacity.

A Side Light From the Source of Osteopathy

In 1874, Andrew T. Still founded osteopathy. He tells about it in his autobiography. He tried to get started in Kansas, but the powers at Baldwin University refused to permit him to expound his doctrines at that institution. In May, 1875, he was in Kirksville, Mo. It appears that he rather anticipated having a hard time, and he tells that his wife promised to stand by him and help him fight his battle. At this point in his story he presents a little incident which we have thought worth quoting: I did not tell her (his wife) that when I came to Missouri I found a letter addressed to my brother Edward, from brother Rev James M. Still, of Eudora, Kans., stating that I was crazy, had lost my mind and supply of truth-loving manhood. I read it and thought, as the eagle stirreth up her nest, so stir away, Jim, till your head lets down some of the milk of reason into some of the starved lobes of your brain. I believed Jim's brain would ripen in time, so I let him pray, until at the end of eighteen years he said:

"Hallelujah, Drew, you are right; there is money in it, and I want to study osteopathy."
—A. M. A. Jour.

An Answer to Antivivisectionists.—By experiments on seventeen hogs there was discovered a serum which will protect swine from cholera. In 1921, owing to extensive use of this serum, this loss was reduced

from \$75,000,000 to \$27,907,000, a saving of about \$47,000,000 to the farmers of this country in the case of one disease. But it is the welfare of animals that we are concerned with in this article. Forty-seven million dollars is the equivalent of say a million hogs. Here are a million animas that have been spared the suffering incident to disease, at the cost of suffering inflicted on a few of their fellows. What real lover of animals could wish the millionn to suffer in order that the few might be spared?—Ernest Harold Baynes, *World's Work*.

A Therapeutic Novelty.

From the N. Y. Tribune, Oct. 19th.

Is it not the Chinese practice that a physician is paid during the good health of the patient and must pay him an indemnity when he falls ill? So one reads in travelers' tales. Perhaps there is merit in the Oriental method. Mr. Samuel M. Vauclain has made that kind of contract with his physician, and Mr. Vauclain scales the heights of efficiency in matters of business.

The doctor has engaged to keep well the builder of locomotives—himself a sort of human locomotive—for ten years for a flat annual fee. Mr. Vauclain promises to be an obedient patient, but an exacting one. If he falls sick the retainer is to be reduced day by day until he gets on his feet again. He will pay for health and the physician for illness, a reversal of ordinary therapeutics.

This is hardly a scheme that the medical profession will be willing to adopt in the case of chronic invalids or valetudinarians. Mr. Vauclain, however, who carries sturdily his sixty-seven years, invites a sporting chance. Both his constitution and his temperament are in the physician's favor, for he is an incurable optimist. Not only does he keep his own nerves well in hand; he spreads encouragement. He has said repeatedly, "There is no reason for this country to worry about anything." Who wouldn't take a risk on such a patient?

He has one shortcoming which the medicine man should remedy. He does not play golf, the game that keeps the doctor away. Mr. Vauclain has spoken outrageously of the sport. "Golf? You spend a day chasing a golf ball around a lot. At night you've got your golf ball. You had it when you started." He added something about the superiority of a wheelbarrow and a hoe. That is pure heresy. Mr. Vauclain ought to know that golf is the approved tonic of every well-regulated captain of industry. His physician should have put that in the unusual but sportsmanlike contract. (See page 404 Nov. Jour.)

Unnamed Communicable Diseases in Virginia

From the Virginia State Med. Jour.

Richmond, Va., July 27, 1923.

There have been in Virginia a large number of cases of illness presenting the following characteristics:

Acute onset with severe epigastric pain, which may extend later to one or both sides of the lower portion of the thorax. The pain is described as very severe, as cutting or as cramplike. The pain is increased by deep breathing, so respiration is shallow and rapid.

A rate of 60 per minute has been noted. An expiratory grunt is frequently observed. The temperature is usually 100 and 102, pulse 80 to 100. The patient looks very ill. The face is pinched or moderately cyanosed. Constipation is the rule and abdominal distention is frequent.

The most severe symptoms are at the time of onset and last from four to twenty-four hours. The duration of acute illness is seldom more than five days but slight elevation of temperature may continue for three weeks. The condition affects children and adults, but is more common in the former. It spreads through families in the manner of a contact infection. There have been no deaths but a few cases have been followed by serious illness of some other type. The condition is apparently an undescribed communicable disease now occurring as an epidemic. This description is issued so that you may be on the lookout for it in your practice. If it occurs or has occurred in your practice, please notify us of the number of cases and the date when your first case was seen.

ENNION G. WILLIAMS, M. O.
State Health Commissioner and Collaborating
Epidemiologist, U. S. P. H. S.

Dr. Mayo on Cancer Cures

At a meeting of the general staff of the Mayo clinic, held a few days ago, Dr. W. J. Mayo referred to recent newspaper comment on his remarks made with regard to the present status of the cancer problem, quoting him as declaring, in substance, that there was no cure for cancer. In the course of a lecture in London in July Doctor Mayo said, "There is no medical cure for cancer;" in other words, no medicine taken internally will cure the disease. Continuing, he said that a great deal of experimental work was in progress in all parts of the world, all of which gradually was adding important knowledge concerning this serious disease, but, unfortunately, these investigations, which have been made on animals, have not, as yet, any direct application to human subjects.

Dr. Mayo, in his talk to his staff, said that the cure of cancer depends on diagnosis and removal at the earliest possible time. In some manner the laity must be taught to understand these truths. Experience in the Mayo clinic has been that 71.8 per cent. of patients operated on for cancer when the disease is still localized, that is, has not extended beyond the primary focus, are cured by operation, and the large majority of the remainder greatly benefited, and many have been cured even when the disease has extended beyond the primary focus. Surgical operation is the only method of removal to be seriously considered, Dr. Mayo continued, because it permits removal, with the growth, of surrounding tissues and glands that may have become involved in the disease.

The x-ray, radium and other agents have a field of usefulness in connection with surgery, but a patient should not be subjected to x-ray, radium or other similar treatments without careful surgical consultation since, if such agents are used while the disease is still local, and fail to cure, the resultant tissue changes delay dependable surgical operation

and may perhaps prevent it. Radiotherapy and other treatments in the hands of untrained persons, or those whose knowledge is limited to one type of treatment, do an enormous amount of harm. Lacking knowledge, these practitioners are not able to differentiate and apply the method which experience would show to be the best method suited to the individual patient. Doctor Mayo now permits these statements to be made in public in the hope of correcting an unfortunate impression which has been spread by many newspapers in this country. Since his return from Great Britain he has had an enormous number of letters from persons suffering from cancer, the letters containing clippings from newspapers in all parts of the United States purporting to quote him saying, "There is no cure for cancer," without reference to his basic statement that surgical removal does cure the disease. What Dr. Mayo actually said was, "There is no medical cure for cancer."

Hospitals; Sanatorium.

The Memorial Hospital and the All Soul's Hospital, Morristown will each receive \$2,500 by the will of George A. Low, a retired importer of teas.

Franklin Hospital Auxiliary.—This auxiliary reports \$924.30 as having been contributed in the county on the donation day campaign.

Jersey City Hospital.—Dr. John Nevin arranged for a series of clinics held last month at the Jersey City Hospital. Associated with the Jersey City Hospital staff were some of the most eminent men in the country in their respective lines. To these clinics all physicians and surgeons in the vicinity were invited and invitations were extended to the staff of most of the hospitals in Northern New Jersey. It is the intention, because of the facilities at hand in the Jersey City Hospital, to make it a teaching center, not only for physicians, but the laity as well. For this reason the meeting on Saturday afternoon was open to the public, women particularly, and was addressed by Dr. Haven Emerson on "Private Responsibility for Health. It is the intention of the hospital authorities to hold these clinics frequently during the year at which the various phases of medicine will be considered and the new ideas and thoughts on medical and health problems will be advanced by some of the ablest physicians in the country.

St. Elizabeth's Hospital, Elizabeth.—The campaign to raise \$400,000 for the enlargement of St. Elizabeth's Hospital here was launched at a dinner at the Elk's Club, which was attended by 400 persons. The campaign is to last ten days. The principal speaker was Dr. George E. Vincent, president of the Rockefeller Foundation.

The campaign closed recently, the amount subscribed reaching more than \$450,000. There has recently been taken a \$3,600 private room by a South Orange resident because a member of his family had been carefully treated there.

St. Paul's Deaconess Home and Hospital.—This institution for the aged was dedicated September 9th at Pompton Lakes. In the hospital department the medical staff is composed of Drs. W. S. Colfax, C. L. Vreeland and D. H. Shippee.

Warren County Hospital.—At a recent meeting of the Warren County Hospital Association it was voted to place a mortgage of \$25,000 on the property, the money to be used in completing and equipping the building. The building is estimated to be worth \$150,000.

Dr. Thomas Dedrick, Washington, N. J., who was a member of Admiral Peary's expedition to the North Pole, recently addressed the Clinton Woman's Club.

Bonnie Burns Sanatorium.—Dr. John E. Runnells, Superintendent, sends the following report for October: On September 30th there were 238 patients in the Sanatorium, 133 males and 105 females. This included 62 children in the Preventorium. Since the last report 22 patients have been admitted, 13 males and 9 females.

Five of these admissions went to the Preventorium.

Among these admissions were four re-admissions.

The admissions are classified as follows: Pre-tubercular, 7; Incipient, 3; Moderately Advanced, 3; Far Advanced, 9. The largest number of patients at any time during the month has been 248. Smallest number, 237. Present October 25th, 248. This number includes 62 children in the Preventorium, and 76 out of the county patients.

Marriage.

BLAUGRUND-KRUEGER.—At Trenton, N. J., October 4, 1923, Dr. Samuel Blaugrund to Miss Helen B. Krueger, both of Trenton.

Deaths.

BERG.—In Plainfield, N. J., November 3, 1923, Dr. Joseph H. Berg, aged 83 years. He was born at Easton, Pa. He was educated at Rutgers College and Jefferson Medical School, Philadelphia, and during the Civil War he was an assistant surgeon with the Twenty-eighth Regiment, New Jersey Volunteers. After the war he practiced for a time at North Branch and Somerville and went to Plainfield in 1888.

CLARK.—At Dover, N. J., November 17th, 1923, Dr. Emma Chambers Clark, aged 57 years.

Dr. Clark was born September 26, 1866, in Malone. She was graduated from the high school there and later from Oswego Normal School. In 1890 she went to Dover to teach in the high school. After teaching eight years she took up post-graduate courses in Syracuse University, Harvard, New York Post-Graduate Hospital and Clifton Springs Sanatorium. Returning to Dover, Dr. Clark began the practice of medicine, which she had since continued. In 1906 she was appointed school medical inspector by the Board of Education.

MADDEN.—In Absecon, N. J., November 27, 1923, Dr. Edmund H. Madden, aged 81 years.

Dr. Madden was born at Millville, N. J.; graduated from the Jefferson Medical College in 1866. He was the oldest physician in Atlantic County and practiced since graduating in Abscecon.

WALTERS.—In the Paterson General Hospital, November 9th, Dr. John Walters of Wharton, N. J., aged 58 years. Dr. Walters was graduated in 1889 from the College of Physicians and Surgeons at New York. He opened an office in Wharton the following year and since that time had practiced there.

MEDICAL EXAMINING BOARDS' REPORT.

| | Examined | Passed | Failed |
|-----------------------|----------|--------|--------|
| Arkansas, May..... | 12 | 12 | 0 |
| Colorado, January.... | 8 | 3 | 5 |
| Connecticut, March.. | 14 | 7 | 7 |
| Georgia, May..... | 11 | 11 | 0 |
| Hawaii, January..... | 4 | 4 | 0 |
| Massachusetts, May.. | 35 | 23 | 12 |
| Michigan, January... | 14 | 14 | 0 |
| New York, February.. | 115 | 81 | 34 |
| Ohio, January..... | 16 | 16 | 0 |
| Penn., Jan., Feb.... | 43 | 39 | 4 |
| South Dakota, Jan... | 8 | 8 | 0 |
| Wisconsin, Jan..... | 8 | 8 | 0 |

Public Health Items.

The City Baby Clinic of the Lord Sterling School, New Brunswick held a birthday party October 2d, when the babies were judged for prizes. Drs. Long, Cronk and Klein were judges. 265 babies are connected with the clinic.

In the not distant future physicians will be expected to publish the mortality of drug treatment, just as surgeons at present are expected to publish the mortality of operative interference. The drug mortality of some physicians is a very high one, yet few physicians have ever realized that they also possess a treatment mortality, which can be compared to the operative treatment mortality of the surgeons.—Frank Kidd in *The Lancet*.

Newark Health Report.—The Health Department reports the following for the month of September: Total number of deaths, 339, or a death rate of 9.3 per thousand population. The principal causes of death were: Tuberculosis, 25 cases; cancer, 38; apoplexy, 18; organic heart disease, 49; pneumonia, 17; cirrhosis of liver, 5; Bright's disease, 21; congenital debility and malformation, 32 cases. There were 930 births during the month, 496 males, 434 females; 873 white, 57 colored.

Diphtheria in Camden.—Forty-nine cases of diphtheria were found in Camden during the month of October, it was reported recently by the Bureau of Health. This was an increase of thirty-seven cases over the September record. The increase was due to the discovery of a number of carriers who probably would not have been found had it not been for the activities of the public health nurses.

New Jersey Mortality Report.—During the month of September there were 2,793 deaths in New Jersey or a death rate of 9.50. There was a slight increase due to measles and pneumonia as causes of death. There were

416 deaths among children under one year of age: 142 deaths of over one year and under five years, and 955 deaths of persons aged sixty years and over.

New Jersey's Infant Death Rate: The infant mortality rate for 1922 for the state was 78.7 per 1000 live births, an increase of 3.1 over the preceding year. The lowest rate appeared in Cape May county and the second lowest in Monmouth county.

In 1921 Gloucester county had an infant mortality rate of 78.1 and in 1922 the rate was 63.5. This decrease was due to the extensive child hygiene work carried on by the bureau of child hygiene in co-operation with the Gloucester county health association.

During the nineteen months of the World War, the battle casualties of the United States were 48,000. During these nineteen months the accidental fatalities in the United States were 126,000, of which 35,000 were industrial, 91,999 in homes and streets, of which latter 25,000 were children of school age, injured on the highways. The moral is that we should make our streets, homes, and places of work more safe.—Weekly Bulletin, N. Y. City Dept. of Health.

Strain and Acute Respiratory Diseases.—There can be no doubt that with acute respiratory disease strain makes up a team of immediate etiologic factors that is responsible for more individual outbreaks of tuberculosis than any other single cause.—Allen K. Krause.

Teeth.—Healthy, normal teeth are a priceless possession, but those which, through pulp removal, have lost their blood supply become objects of suspicion. If in addition, infection has occurred at the apex of the root, they become a questionable blessing, while in cases in which this infection has become a focus of ill health, the tooth becomes a menace and its possession a curse.—Thoma, K. H.: *Teeth Diet and Health*, New York.

Occupation and Tuberculosis.—Many occupants in which the mortality from tuberculosis is high are not in themselves conducive to tuberculosis, but are occupants in which employees are underpaid or overworked, or which are sought by the physically unfit, the improvident, or persons ignorant or careless of the measures necessary to keep healthy. Outside of certain dusty occupations, the lowest tuberculosis mortality is found among the callings which are characterized by comfortable living and moderate exertions.—F. C. Smith, *Public Health Ref.*

Rest the Restorer.—Experience will prove to any one that, except in cases of acute disease and very ill patients, there is no appetizer for the consumptive like rest; there is no restorer of aching, tired limbs like rest; there is no fever-reducer like rest.—A. K. Krause: *Rest and other things.*

Rest in Tuberculosis.—Rest remains the sovereign remedy for tuberculosis. More direct and spectacular methods of treatment—inhalaions, injections, drugs by mouth—come

and go: The years since 1900 have spawned hundreds of them. Few have survived the sensation of their momentary announcements; none has earned a vogue. Rest alone has returned thousands of consumptives to productive life. Of those who, while living an active life, relied on drugs or vapor or "serums" or vaccines to fight their battle, few have made the journey back.—Allen K. Krause

Save the Mothers and the Babies

In the period from 1915 to 1921, there was a substantial reduction in the infant mortality rate in the birth registration area of the United States, but five nations still have lower rates than the Americans. A study of vital statistics showed that little progress was being made in reducing the deaths in early infancy, including deaths caused by premature birth, congenital debility, and injuries at birth, which have maternal clauses. Consideration of infant mortality therefore inevitably led to the question of the care mothers are receiving before, during, and after child-birth. Unfortunately, the maternal death rate in the United States has increased rather than decreased, so that the American rate for 1920 the highest among all the nations for which recent statistics are available. With an annual loss of approximately 200,000 babies and 20,000 mothers, the need of extending on a national scale the successful local efforts to provide better care for mothers and infants was obviously necessary.—The North American Review.

Schick Test on School Children.—Dr. I. W. Knight, of the State Board of Health, assisted by Dr. J. A. Beek, local health officer and other physicians, began the Schick test for diphtheria on the public school pupils of Gloucester, N. J. About 1,200 of the girls and boys brought consent cards from their parents, and any one found subject to the disease will be immunized.

The local health board is paying the entire expense, as there have been cases of this disease every month for the last three years.

Benign Albuminuria of School Children.—On examining five thousand school children Paul Lauener, Schweizerische medizinische Wochenschrift, found that 6.7 per cent. of those between the ages of six and seven years showed albuminuria, as did also twenty-seven per cent. of those between the ages of ten and eleven years, and thirty-eight per cent. of those between fifteen and sixteen years of age. The group of children that came from more prosperous homes and showed more marked growth showed more cases of albuminuria. The kidney is involved only as an excretory organ and the growth is subjected to its own conditions of metabolism, which lead to albuminuria. Treatment for this condition is unnecessary and may even be harmful, as it results in psychoneurotic conditions.

Mortality Record, Six Months of 1923.—The July Bulletin of the Metropolitan Life Insurance Company says: The general health record during the first half of 1923 has been

more than satisfactory. Following a most unpromising beginning, chargeable wholly to the influenza outbreak of the early months of the year, there has since been in evidence a consistent improvement. At the end of the half year, we find the death rate of the millions of white policy holders to be only one-third of one per cent. in excess of that for the corresponding period of 1922; in the case of the colored policy holders the increase was 4.2 per cent. These are small differences and are encouraging indeed, coming as they have in the face of the high influenza-pneumonia mortality of the first three months. The excellent health record of the second quarter has almost wiped out the large adverse margins that were in evidence three months ago; for, at that time, the recorded mortality among white policy holders was 8.9 per cent. and of the colored, 11.5 per cent. higher than for the first quarter of 1922. Among the encouraging features of the health record of 1923, to date, the most outstanding single item is the continued decline in the tuberculosis death rate. Almost beyond peradventure, a new minimum will be recorded this year in the mortality from tuberculosis disease. The winter and early spring months—the season in which the mortality from tuberculosis is always heaviest—have passed, with a decline in the death rate among white policy holders of 5.3 per cent. and among colored of 2.4 per cent. from the record of the first half of 1922. The continuous decline (except for a single year) that has been observed since 1911, is still going on. Another encouraging item of the 1923 health record is a decline in cancer mortality. There has been a drop of 4.2 per cent. among the white policy holders and a small decline among the colored.

OCCUPATIONAL DISEASE

I only kissed her on the cheek;
It seemed a simple frolic;
But I was sick in bed a week—
They called it painter's colic.

—Chicago Med. Rep.

Personal Notes

Dr. Arthur Leland Smith, New Brunswick, was given a testimonial banquet on the evening of November 14th in the Ballentine Gymnasium building of Rutgers College, in recognition of his twelve years' service to the Public Schools of the city, five years as president of the Board of Education. Over 200 citizens were present. Governor Silzer of New Jersey, former Superintendent of Schools and present Superintendent Sickles, Mayor Morrison, H. G. Parker, president of the Bank of New Jersey, Judge P. F. Daly and D. J. Wray, present head of the Board, made highly commendatory addresses. Prof. J. H. Logan acted as toastmaster. Dr. Smith was presented with a handsome Howard watch by the Board of Education and he made an eloquent and modest speech expressive of his appreciation of the honor done him and the gift received.

Dr. Julia C. Mutchler, Dover, was elected last month a member of the Dover Board of Aldermen.

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